

Hauora Tuwhena: Kaupapa ta tataritanga hauora Maori 1990-99

Disproportionate health: a policy analysis of the health of Maori 1990-99

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Abstract

This thesis examines the effects of public sector restructuring on Maori health development during the 1990s, primarily through an analysis of health sector reform, changes to health policy direction, and the response of Government to Maori development issues. The relationship between health development and socio-economic status is also examined in order to determine what the cost of the economic and political climate of the decade has been for Maori. A key focus is the partnership, and obligations thereof, established by the Treaty of Waitangi between Maori and the Crown. As Government has acknowledged the Treaty as the founding document of Aotearoa New Zealand, any discussion of Maori health must start with the Treaty as a basis.

The theoretical framework adopted employs social policy and sector analysis in order to assess whether health outcomes for Maori have improved during the 1990s. Institutional influence on the policy process is also examined as part of this framework. The influence of these procedures on policy development and general health outcomes for Maori during the 1990s is assessed, while health outcomes for Maori women in particular are discussed as a case study. This thesis examines why disproportionate health development still occurs in terms of Maori and non-Maori health despite Maori health having been designated a health gain priority area since 1984, and Government requirements that mainstream accountability to Maori be improved.

As part of this examination, health promotion and intervention strategies have been assessed as these are seen as an effective first point of contact for groups traditionally disadvantaged in terms of health outcomes. Moreover, areas have been highlighted where improvement to policy could enhance positive Maori development, as positive Maori development is seen as essential to improving health outcomes for Maori. Regional policy efforts for promoting Maori health gain are also examined.

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Glossary

hapu	sub-tribe
hauora	well-being, spirit of life, health
he mate Maori	Maori way of life, customary practices
hinengaro	mind
iwi	tribe
kaupapa	philosophy, theme, ideas
kaupapa mahi	procedure
kaupapa Maori	strategy based on Maori philosophy
kawa whakaruruhau	cultural safety
kohanga reo	language nest
kuia	female elder
mana Maori	Maori jurisdiction
manuhiri	guest, visitor
marae	meeting place
mauri	life principle
nga ahuatanga noho-a-tangata	socio-economic circumstances
nga waitohu	set of indicators
paihere tangata	relationships
rangatiratanga	sovereignty
rapuora	health search
rongoa	medicine
runanga	assembly
taha Maori	Maori perspective
tamariki	children
tangata whenua	local people
taonga	something of value, treasure
te ao Maori	cultural identity
te iwi Maori	the Maori people of Aotearoa
tinana	body
tipuna	grandparent, ancestor

tino rangatiratanga	absolute sovereignty
tohunga	learned expert
turangawaewae	hone land
tuwhena	disproportionate
wahine	women
wairoa	health
wairua	spirituality
whakapapa	genealogy, cultural identity
whakawhanaungatanga	customary practice of integrating relationships
whanau	family
whanaunga	relative, kinship
whanaungatanga	relationship
whangai	nourish, care for
whare tangata	relation by marriage

Introduction

Overview

According to Pomare (1988, p.711), the health of Maori people has been under close scrutiny since the publication of Maori Standards of Health in 1980 by the Medical Research Council. Pomare claims that as discrimination affects Maori people in terms of health outcomes, Maori should be recognised as having special health care needs. Consequently, successive Governments during the 1980s and 1990s have committed themselves to improving health outcomes for Maori by designating Maori health a health gain priority area. A current objective of health policy is to reduce levels of disparity in terms of health status between Maori and non-Maori so that Maori, in the future, will have the opportunity to enjoy at least the same level of health as non-Maori.

In spite of this commitment, disparities between Maori and non-Maori in terms of health status have continued to increase during the 1990s. According to the Ministry of Health (1997c, p.62), the gap between Maori and non-Maori is widening not only in terms of life expectancy, but also in terms of socio-economic status, relative income levels, mortality rates, and the onset of chronic illness or disease. As a result, the Ministry has identified that challenges to improving Maori health outcomes lie in: mainstream providers taking responsibility for Maori health; the identification of lifestyle and socio-economic factors that cause ill health; and the deployment of appropriate frameworks for positive Maori development (Ministry of Health 1998a, p.5).

The purpose of this thesis is to examine the development of health policy and sector change during the 1990s, and analyse what the implications have been for Maori health development. In order to determine whether disparities between Maori and non-Maori have been exacerbated by changes to the sector and policy direction, health outcomes for Maori in general, and Maori women specifically, as a case study, will be examined. This thesis will attempt to determine this by examining policy content, assessing community initiatives, and speaking with health sector employees. Both Te

Puni Kokiri and the Ministry of Women's Affairs have noted that, in spite of Government efforts to bolster socio-economic and health outcomes for Maori women by increasing services, achievement rates for Maori women have continued to drop.

This thesis will also seek to identify the main factors which protect and promote health gain as these are identified by the National Advisory Committee on Health and Disability (1998, p.8) as being equally important to improved health outcomes as effective policy development. Consequently, health promotion and education strategies will be assessed, as I will seek to indicate how Government could work to ensure that such strategies and programmes are appropriate and effective for Maori. The Ministry of Health sees health promotion as an essential method of improving health outcomes for Maori through improved ownership (Ministry of Health 1997b, p.6). Mainstream responsiveness by government agencies to Maori will also be examined, as will issues of appropriate resource allocation, funding, and equitable socio-economic policy development.

Government also has an obligation under the partnership established by the Treaty of Waitangi to work to improve health outcomes for Maori, as one of the major purposes of the Treaty is the survival and development of Maori people (Te Puni Kokiri 1999c, p.8). In terms of health reform during the 1990s, specific policy implications have arisen from the debate over the provision of the Treaty and the guarantee of rangatiratanga to Maori. An effective assessment of Maori health need and outcomes cannot be made without assessing Treaty implications for Maori health development. This thesis will examine the effect on policy development from rangatiratanga requirements, and the promise to Maori to protect socio-economic and health outcomes.

Community-based initiatives also need to be examined in order to suggest policy directions that could be adopted to help improve health outcomes for Maori. A number of community-based initiatives are based on principles of: ensuring that programmes are client-focused; managed services which are designed to make a difference to health outcomes for Maori; developing local solutions to local problems; building relationships with resource people and organisations; and drawing on the specialised knowledge of local communities (Ministry of Health 1998a, p.21).

Community-based programmes also take into account the wider links between whanau, the community, and the national population. All of these factors have implications for policy development. A number of Maori health theorists (Hayes 1999, Rahu 1999, Puketapu and Pihema 1999) argue that community-based initiatives more effectively target barriers to health that Maori face than policy-based initiatives, therefore creating opportunities for health gain. Consequently, it is important to assess the development of these programmes and the implications for policy.

This thesis asks whether accompanying changes to social policy, such as housing policy and welfare cuts, have contributed to poor health outcomes for Maori. Durie (1999) argues that changes to the health system will not, by themselves, address the disparities and disproportionate health balance between Maori and non-Maori. Maori have experienced reductions in income during the 1990s, from benefit cuts in 1991 and 1998, and from cuts to jobs in low-growth employment areas where Maori have traditionally been employed. Lower income levels can lead to a situation where a higher percentage of income is spent on housing, thus necessitating trade-offs in other areas such as housing, food, heating, education and health care. Socio-economic outcomes have follow-on effects for health development. A third purpose of this thesis is to determine what the consequences of limited socio-economic options have been for Maori in terms of health outcomes.

Theoretical approach

Policy analysis requires an assessment of contemporary and historical factors which have contributed to the development of current health outcomes for Maori. In terms of this thesis, this assessment will occur in four parts: first, Maori health development and sector reform during the 1990s will be analysed; secondly, the theoretical approach adopted will be outlined; thirdly, changes to socio-economic policy and outcomes will be assessed; and finally, health policy development during the 1990s will be analysed. I will also examine changes to health outcomes for Maori by using Maori women as a case study to illustrate the impact of sector reform on Maori health development during the 1990s.

Primarily, this thesis will examine: Maori health gain; positive Maori development; disparities in health outcomes between Maori and non-Maori; implications for policy development arising from the Treaty of Waitangi; and policy direction during the 1990s. The theoretical framework employed analyses policy from an institutional perspective, and through an examination of the policy process. Policy analysis should focus on a diagnosis of the problem, identification of possible alternatives, adoption of a new policy based on these alternatives, and implementation and evaluation of the new policy. Where appropriate, this may also lead to termination of the policy where the new policy is not effective or is not producing desired results.

In assessing the impact of this process on Maori health development and gain, it is important to assess the role played by institutions during this process. Institutions structure the policy environment by determining which actors are permitted to enter the policy environment and those that are not, and by defining procedures for making policy decisions. Institutional structures also create rules regulating the possession and use of political rights and resources (Orr 1997, pp.62-64). Consequently, institutions influence policy direction by structuring the policy environment and by affecting the policy process. The way in which policy options are framed can affect the impact on different groups within the population (Blank 1994, p.137).

It is important, therefore, to analyse the institutional environment in which health policy was developed during the 1990s as this environment has had an impact on health outcomes for Maori. It is also necessary to evaluate policies within a social, economic, and cultural context as this allows for more effective analysis (Palmer and Short 1994, p.29). In spite of Government requirements that mainstream responsiveness to Maori is improved, and Maori health gain be pursued by designating Maori health as a health gain priority area, disparities between Maori and non-Maori in terms of health status appear to have increased during the 1990s. This thesis will argue that in order to improve health outcomes for Maori, appropriate policy direction needs to be developed and mainstream responsiveness improved.

Applying this framework to an analysis of policy development during the 1990s, I will examine the following hypothesis:

- **Hypothesis: Disparities between Maori and non-Maori in terms of health status have been exacerbated by health sector reform during the 1990s. The cost for Maori of the economic and political climate of the 1990s has been disproportionate health development compared with non-Maori.**

This hypothesis is examined in an attempt to demonstrate that in spite of targeting Maori health and socio-economic outcomes in policy, particularly through the policy of mainstreaming, Government has failed to produce equitable health outcomes for Maori. This thesis will also ask four research questions to test the hypothesis. These will be explored in order to assess if the health needs of Maori are being effectively provided for through policy development. The supporting questions are:

- **What were the major economic influences on health policy development during the 1990s?**
- **How have these influences shaped health outcomes for Maori?**
- **What adjustments have been made to policy to help improve socio-economic and health outcomes for Maori?**
- **Have any health gains for Maori occurred?**

Methodology

A combination of policy analysis of documents and reports from the 1980s and 1990s, other relevant literature, and sector interviews has been employed as the methodology for this thesis. The hypothesis and supporting research questions will be examined through the application of policy documents to the New Zealand health sector. The sector interviewees were chosen from a cross-section of people employed in the health sector, and were conducted over a period of six months from October 1999 to March 2000 in Christchurch, Wellington and Auckland. Interviewees included policy analysts from Te Puni Kokiri, the Ministry of Women's Affairs, and the Ministry of Health, and community workers from Maori health programmes in Lower Hutt, Auckland and Christchurch. Other interviewees included staff from the Eru Pomare

Maori Health Research Centre in Wellington, and staff of the Maori Studies Department at Massey University, Palmerston North. These latter interviewees were selected because access to other community groups was limited due to funding, access, and timing restraints. It is felt, however, that the interviewees selected can provide a useful cross-section analysis of challenges facing Maori today in terms of health development - despite being a relatively elitist group. It is suggested that in future research other community groups be consulted.

This thesis is approached in four parts - an introduction, a text of five chapters, a case study, and a supporting conclusion. The introduction addresses the rationale for the thesis, why the hypothesis was selected, and how information was gathered to answer these questions. Chapter one examines the relationship between Maori health development and sector reform during the 1990s. The theoretical framework is developed in chapter two, focusing on the policy process and institutional influence on policy development. In chapter three, Maori health development during the 1990s and the impact of factors such as the Treaty of Waitangi on this development are discussed. Socio-economic determinants of health are examined in chapter four. Chapter five looks at the development, and analysis of, health policy during the 1990s, while Maori women's health development as a result of sector change is examined in chapter six. The conclusion discusses implications for Maori health outcomes as a result of policy development and sector initiatives during the 1990s.

CHAPTER ONE

Maori Health Development and Sector Reform

During the 1990s

Introduction

Health reform can take a number of forms and encompass many different objectives but a primary goal of reform should be to improve the current system where it is perceived to not be working or is less efficient than is desired. When undertaking a process of reform Government should be concerned with improving population health outcomes, encouraging services that are equitable, and improving patient autonomy. Health policy changes are often referred to in the literature as “reforms”, a term which Barrett argues implies the existence of a qualitative improvement in health services deriving from these changes (Barrett 1992, p.1). Changes to health policy may result in improved health outcomes if Government: identifies why certain policy objectives are not being achieved, targets risks to health outcomes as a result, develops appropriate strategies to counter the effects of these risks, and identifies other variables which are impacting on the development of health status. These variables include, but are not limited to: issues of resource allocation; Crown- and provider-capture of the health sector; socio-economic disparities within the population; and the nature of the policy development process itself.

Durie (1999) suggests that the disparities which exist between Maori and non-Maori in terms of health status are influenced by the presence of each of these factors. Durie further suggests that changes to the health system will not, by themselves, effect positive change for Maori nor will they address the fundamental nature of these disparities. Consequently, in order to assess the impact of policy change on the development of Maori health status during the 1990s, it is important to undertake an analysis of the development of policy during that decade and to highlight areas which warrant attention. The purpose of this chapter is to examine the changes which have occurred in the health sector during the 1990s and to relate those changes, and resultant policy focus, to Maori health development during this period.

The foundations of policy assessment should include: diagnosis of the problem(s); identification of possible alternatives; implementation issues; other policy goals such as equitable distribution of resources and equity in health outcomes; and policy evaluation, including a cost-benefit analysis. Policy analysis also requires an evaluation of contemporary and historical factors that have contributed to the development of the current health sector, the identification of areas where there have been deleterious consequences, and recognition of areas where positive change has occurred. In terms of the impact of health sector change on the development of Maori health status during the 1990s, it is essential to recognise the role played by these variables and to examine the influence of policy development itself during this time.

A current objective of health policy is to improve Maori health outcomes so that in the future Maori will have the opportunity to experience a level of health similar to that enjoyed by the majority of non-Maori. The Ministry of Health (MOH) suggests that strengthening public health outcomes, in particular improving community participatory action, is one way in which Maori health outcomes can be improved and disparities reduced. The Ministry has also recommended that Maori health outcomes may be improved through attention being paid to: health data analysis; needs assessment including planning for and evidencing of effectiveness; primary and preventative health measures; role clarity including organisational focus and performance accountability; recognition of access inequities for different population groups; Maori participation in service delivery and purchasing decisions; new arrangements for primary care funding; and new provider and innovative service delivery (Ministry of Health 1998f, p.31). The focus placed on the above methods by the Ministry of Health for reducing levels of disparity between Maori and non-Maori in terms of health outcomes is important in assessing the impact of these changes. This focus provides a point of reference for analysis and enables the process of reform to be related to Maori health development during the same period.

Neo-liberalism and health sector reform

The introduction of the Health Reforms in 1991 reflected a continuation of the state and economic restructuring programme begun under the Fourth Labour Government in 1984. As part of this restructuring programme, Treasury moved in the mid-1980s

to reduce spending on Vote: Health. This recommendation was included in its briefing, Economic Management, to the new Government in 1984. Treasury analysts felt that the commitment to health under the Social Security Act of 1938 was unsustainable at current rates due to the fiscal outlay required and the percentage of Gross Domestic Product (GDP) being spent on health. The passing of the Social Security Act of 1938 led to the creation of a welfare state in Aotearoa New Zealand. A key component of the Act was an open-ended commitment to provide health care for all New Zealanders not determinant on the ability to pay. Health care was seen as a right, not a privilege. In contrast with this social philosophy, the economic climate of the mid- to late-1980s, and early-1990s, was dominated by a New Right, or neo-liberal, agenda of curbed fiscal outlay by Government, reduced State dependency, and increased individual responsibility for social outcomes.

Conner (1995) argues that the New Right agenda was based on several broad principles: the notion of a self-regulating economy; extreme individualism; the right to private property as inviolate; rejection of egalitarianism and redistributive justice; the abandonment of active fiscal and monetary policy; and a restructuring or dismantling of the welfare state (Goldfinch and Roper 1993, pp.56-64; Rudd 1993, p.245; Stephens 1992, p.6). In line with the desired restructuring or dismantling of the welfare state, social policy was subjected to a number of reviews, such as the Health Benefits Review (1986), which resulted in diminished State provision, including benefit cuts and the introduction of increased user charges for health care. As the health sector was not immune from the New Right agenda, an analysis of the Health Reforms by Claudia Scott in August 1991 suggested that these reforms were part of a Government strategy to curb economic spending on social policy. Neo-liberal reform is concerned with improving the efficiency of the market and Scott contended that Government philosophy at this time was to offer assistance to a limited few as part of a wider strategy to reduce State dependency and to curb expenditure.

Scott argued that Government determined that it might be better to “provide generous assistance for a limited few than to use the same dollars spread across a wide range of groups” (Scott 1993, p.19). Scott further argued that the rationale behind this policy centred on the fiscal advantage of targeting disbursement to certain groups only, as Government funding, in terms of beneficial social outcomes for all New Zealanders,

was proving unsustainable (Scott 1993, p.19). This strategy was implemented in the health sector despite the rhetoric in the 'Green and White Paper' of 1991, Your Health and the Public Health, which purportedly sought to increase health equity and access for all New Zealanders. This was to be achieved, however, by generating greater efficiency in the system. Actors' abilities to achieve their goals in this new environment depended on the nature of reform goals, the resources they had at their disposal, and how much social and political power they wielded (Orr 1997, p.62).

For traditionally disadvantaged groups, such as Maori, the elderly, and those in low socio-economic brackets, exchangeable resources and socio-political power were, and are, limited or even non-existent for some. These groups represent people with special health care needs who would like to take responsibility for their own health outcomes but who are unable to due to a lack of political voice and economic resources (Pomare et al. 1988; Health Funding Authority 1998c). This was the policy environment many Maori found themselves competing in terms of social and health policy from 1984 onwards, but particularly during the years from 1991 to 1996. Although much of the economic restructuring programme had been completed by 1991, this period stands out as important in terms of assessing the impact of health sector change on Maori outcomes. During this time, a number of Maori experienced harsh outcomes in terms of socio-economic status and health development.

In terms of assessing Maori health development during the 1990s, attention needs to be paid to the impact of wider contextual factors, such as socio-economic status, on health outcomes. Te Puni Kokiri (1999b), Waldegrave and Sawrey (1994), Mowbray and Dayal (1994), and the National Advisory Committee on Health and Disability (1998), provide evidence during these years of: a rise in serious housing need for Maori; an increase in the cost of education and health services generally; a decrease in terms of median annual incomes compared with non-Maori; and an increase in Maori unemployment levels. These factors are acknowledged in the literature as having an important influence on health development. Beaglehole and Howden-Chapman (1992), cited in Nuthall (1992, p.i), argued that the emphasis placed on market forces in the restructuring of the health sector downplayed the importance of these wider contextual factors in health development. Furthermore, they contended that this

applied to economic and social policy development in general during the 1990s. This is discussed further in chapter 4.

In the introduction to Your Health and the Public Health (1991), Simon Upton, the Minister of Health, claimed that reform of the health system “is only worth doing if the outcome is a better system with benefits for all New Zealanders” (Department of Health 1991, p.1). Upton argued that the primary objective of the reform process was to secure for everyone “access to an acceptable level of health care. Low income should not create a barrier to quality care” (Department of Health 1991, p.1). According to Upton, the new health structure had objectives of: improving access for all New Zealanders to a health care system that is effective, fair and affordable; encouraging efficiency, flexibility and innovation in the delivery of health care to the community; reducing waiting times for hospital operations; widening the choice of hospitals and health care services for consumers; enhancing the working environment for health professionals; recognising the importance of the public health effort in preventing illness and injury and in promoting health; and increasing the sensitivity of the health care system to the changing needs of people in our society (Department of Health 1991, p.3). However, despite apparently utilitarian notions of improving health outcomes for all New Zealanders, the Health Reforms were seen as having less to do with health and more to do with structural domination of the sector and cost containment.

In an article for ‘North and South’ magazine in 1993, McLoughlin argued that health outcomes were “purely incidental” to the 1991 Reforms and that these reforms had more to do with accountability, cost control, structural domination and management than they had to do with health. McLoughlin asked what exactly was it that Simon Upton was trying to achieve through these reforms (McLoughlin 1993, p.65). McLoughlin viewed the Reforms as the chosen method of introducing New Right ideology to the health sector through the application of a neo-liberal framework. In relation to health, this framework espoused two main principles. One, health could be dealt with in the same manner as any other economic commodity through the application of a market framework which gave the consumer choice in service provision. Two, that health and health policy were exclusive entities not affected by other social policy or socio-economic variables.

This framework also employed a narrow biomedical definition of health and made only limited allowance for the impact this framework would have on variables such as class, ethnicity, race and gender. This definition of health excluded Maori concepts of health which approach health development holistically, and which target the person's social environment in addition to physical symptoms. Neo-liberal theory maintains that the presence of variables such as class, ethnicity, race and gender is the result of individual choice and suggests that, despite these variables, rational self-interested actors will maximise choice for themselves through utilising the options provided by institutions and the market. Institutions are seen as providing the rules and structure necessary to adjudicate the market and the use of political rights and resources (Orr 1997, p.64). Neo-liberal theory considers the presence of socio-economic and socio-cultural variables to be naturally occurring parts of the market structure. Consequently, neo-liberal theory argues that these will be addressed through individualised rational choice and the economic structure in place.

The neo-liberal agenda adopted by the National Government employed a single focus approach that focused on two key points: one, it advocated a generic approach that predominantly sanctioned economics; and two, it assumed that individuals consciously rationalise their social and economic choices as promoted by rational choice theory. Rational choice theory centres on the social and political choices of actors. A central tenet of this theory is that actors are rational and self-interested. Orr (1997) argues that under rational choice theory individual actors are assumed to have stable, consistent and exogenous preferences. Moreover, actors pursue these preferences by considering alternative bargains in relation to their "expected consequences", and chose the combination of bargains that optimise their preferences (Orr 1997, p.61).

Furthermore, the ability of an actor to realise his or her dreams in this system is dependent on what those desires are, what exchangeable resources the actor has, and what political rights the actor is entitled to. The greater the rights and resources, the stronger the bargaining position maintained by the actor (Orr 1997, pp.61-62). For traditionally disadvantaged groups such as Maori and Pacific Island people, limited exchangeable resources may restrict the realisation of their dreams. Consequently, the possibility of traditionally disadvantaged groups achieving improved outcomes, such

as health gain and/or enhanced socio-economic status, can be limited by the nature of this policy environment.

Neo-liberal frameworks centre on the notion that, with regards to health care, individuals are guided by actions which maximise their options and that they are aware of all options in making their choices. Neo-liberal theory also maintains that consumers are better off through being given options in health care provision than if they were mostly restricted to a public, universal health care system. Under the market ethos, Government promoted the idea that the introduction of choice in health care provision would iron out other variances in health care access and affordability. The option of choice in health care offered individuals some degree of freedom from a bureaucratically controlled system. A major critique of neo-liberal theory, however, is that certain groups are already disadvantaged under the system because of a lack of skills, knowledge or resources and, as a result, they are unable to engage freely in market transactions (Cheyne et al. 1997, p.3). Consequently, although market outcomes may be both “unequal and unintentional”, they are also seen as predictable because of societal imbalances (Cheyne et al. 1997, p.3). As a result, groups with distinctive or special health care needs, such as Maori, have come to be seen as being penalised in terms of health outcomes. An implication of this argument is that groups who were already marginalised or disadvantaged in terms of health outcomes, arguably, became more so under a market paradigm.

Changes to Policy Direction Post-1996

Policy development was to follow this directional shift until 1996 when the General Election resulted in a Coalition Government of National and New Zealand First. The new Government introduced further change to the health sector by implementing the Coalition Agreement on Health (1997), although these changes were less controversial than those introduced in 1991 and more geared towards improving health outcomes. The Coalition Agreement on Health worked with the existing structure set up by the Reforms of 1991 by maintaining the purchaser-provider split but with a fundamental difference, a single funder. A single funder format was created in 1997 and was administered by the Transitional Health Authority (THA) for

the first year of the new structure. This was followed in 1998 by the establishment of the Health Funding Authority (HFA).

Under the new structure, Government was less concerned with pursuing a profit focus and more concerned with improving health outcomes; the focus was on health gain. Through the reforms of 1996/97, Government sought to implement a vision of sustainable development for the health and disability sector over the long term. Government sought to achieve this by focusing on five themes identified by a Steering Group to Oversee Health and Disability Change. The Steering Group was established to provide advice to Ministers on the impact of the Coalition Agreement on Health, as this Agreement signalled structural changes for the health sector (Te Puni Kokiri 1997, p.19). The vision of the Steering Group was to improve the health and independence of New Zealanders (Wenley 1997, p.12).

The five themes identified by the Steering Group indicated that there was a need within the health and disability sector: for a long term focus; for constructive relationships; for a policy focus on outcomes; for openness to offset inevitable tensions which may arise; and for a recognition of Treaty of Waitangi obligations (Wenley 1997, p.12). The Steering Group also recommended that a new Maori policy framework be employed in order to ensure that Maori health needs were addressed in the new health sector. The Rangatira framework which resulted from this recommendation is pertinent in terms of improving health outcomes for Maori. The framework seeks to improve access to mainstream services for Maori in addition to improving intra- and inter-sectoral collaboration.

The Rangatira framework views improved access to mainstream services as integral to improved health outcomes for Maori, as 80 to 85 percent of Maori continue to access mainstream services. Consequently, for those Maori who choose to access mainstream providers, services need to be “safe, equitable, culturally effective, and appropriate” (Cunningham and Durie 1999, p.251). According to the Ministry of Health, Government has also realised that if there are to be improved health outcomes for Maori, a necessity exists for improved public health strategies, increased numbers of Maori providers in addition to improved mainstream services, and an increased professional Maori workforce. Government has also acknowledged the utility of and

benefits from “developing the Maori health sector as central to improving Maori health status” (Ministry of Health 1998f, p.53).

Government also has an obligation under the terms of the partnership established between Maori and the Crown by the Treaty of Waitangi to seek improvement to Maori health outcomes. One of the main purposes of the Treaty is the survival and development of the Maori people (Te Puni Kokiri 1999d, p.8). In terms of health sector reform in the 1990s, specific policy implications have arisen from the debate over the provisions of the Treaty and the guarantee of *rangatiratanga* to all Maori, both as Maori and as citizens of Aotearoa New Zealand. According to the Ministry of Health, Maori view the Treaty as the *kawenata* (covenant) which embodies their current efforts in health. It provides an umbrella for Maori aims and aspirations and is the framework for expressing health priorities on both a rights and needs basis (Ministry of Health 1995b, p.8).

Rangatiratanga is defined as a key reference and concept in the Crown’s management of Maori affairs, and is explained as the principle of collective action which underpins the ways in which Maori organise themselves and relate to other parts of the community. It is through the exercise of *rangatiratanga* that a group maintains its identity and protects and develops its culture (Te Puni Kokiri 1999d, p.3). People who are disadvantaged in terms of health outcomes, employment, education and income, or suffering high rates of imprisonment cannot, however, effectively exercise *rangatiratanga* (Te Puni Kokiri 1999d, p.7). Implications for Maori health development from the Treaty partnership between Maori and the Crown will be further examined in chapter three.

In order to assess the development of Maori health during the 1990s, it is also important to review results from the Decade of Maori Health and Maori Development. The Decade came to a close in 1994 at Hui Te Ara Ahu Whakamua.

Recommendations made by delegates at this hui are important in assessing the impact of sector change on Maori health outcomes and examining why Maori continue to lag behind non-Maori on most major health indices. Although delegates at Te Ara Ahu Whakamua demanded accountability on the part of Government for poor Maori health development, they also conceded that good health starts at home. Consequently,

delegates recommended that an integrated approach to health, and to health policy, was needed. Health policy was seen as a key factor in reinforcing healthy lifestyles (Te Puni Kokiri 1994b, p.5). Government was asked to be more responsive to Maori and to contribute to Maori health status by: being accountable to Maori; by clearly defining respective roles and responsibilities; through Maori resource development; and by creating a “level playing field so that Maori can compete on equal terms” (Te Puni Kokiri 1994b, p.6).

As data has previously only been collected on specific types of mortality and morbidity and not on measures that could be associated with a Maori concept of health, comparisons between Maori and non-Maori health development has been limited. Despite these limitations, three major disparities are usually highlighted (Te Puni Kokiri 1997, p.11). These disparities are: Maori life expectancy has improved over the last decade but it is still five to six years behind non-Maori; the major causes of death are the same as for non-Maori, but the rates are 1.5 times higher for Maori; and Maori are more likely to suffer from respiratory disease, heart disease, diabetes, cataracts, kidney disease and circulatory disease than non-Maori, by more than two times in some cases (Te Puni Kokiri 1997, pp.11-12). For example, in the Auckland region in 1993, hospitalisation rates for chronic rheumatic heart disease were 6.3 times higher for Maori women than non-Maori women, and 3.5 times higher for Maori men than for non-Maori men (Te Puni Kokiri 1993c, p.6).

Moreover, in 1999, the Ministry of Health (MOH) found that for most major diseases and injuries, including ischaemic heart disease, stroke, lung cancer, diabetes, and road traffic injuries, Maori incidence, prevalence, and mortality rates were 50 to 100 percent higher than non-Maori rates once adjusted for age. The Ministry of Health also found that Maori and Pacific people have rates of avoidable hospitalisation approximately 60 percent higher than non-Maori (Ministry of Health 1999c, p.380). According to the MOH, ischaemic heart disease is a more important cause of death for Maori and Pacific people in the 25 - 44 age group than for non-Maori. Furthermore, the Ministry found that among middle-aged adults (45 - 64 years), and older people (65 years and over), diabetes and lung cancer are responsible for a much higher rate of mortality for Maori and Pacific people than for non-Maori (Ministry of Health 1999c, p.93).

These findings are supported by a study by Pomare et al. (1995, p.66). Pomare et al. studied Maori standards of health from 1970 to 1991, and found that from 1987 to 1991 Maori women in the 15-24 age bracket had similar rates of death to non-Maori for all major causes except for: all forms of heart disease (80 percent higher), and respiratory disease (50 percent higher). Cancer was the leading cause of death in 1991 for all Maori, with Maori rates of cancer of the lung, stomach and cervix more than 2.5 times higher than non-Maori rates (Pomare et al. 1995, p.124). Pomare et al. also found that:

- although Maori health outcomes have continued to improve, it has been at a rate less than expected
- it is likely that the lack of improvement has been contributed to by socio-economic factors such as income and employment which in some groups have worsened during this time
- while some improvement in socio-economic indicators has been noted, particularly in education, changing state sector policies and their impact on employment and income may have prevented the benefits of Maori development from reaching Maori individuals and whanau (Pomare et al. 1995, p.150).

Pomare et al. (1995) argue that income has been found to be a key influence on health with the health of a population being affected by the degree of inequality of income distribution. The authors found that in the ten years from 1981 to 1991 a widening inequality in income distribution was occurring and more Maori households were falling into lower socio-economic brackets than previously. By comparison, there were more non-Maori households, apart from those aged sixty and over, in the higher brackets (Pomare et al. 1995, p.149). The literature almost universally points to the impact that education and income have on health development. Health development analysis should take into account whether improvement or regression is occurring in terms of independent variables such as housing, income, and education and/or dependent variables such as issues of resource allocation and the structural arrangement of Government.

Beaglehole and Howden-Chapman (1992), cited in Nuthall (1992, p.i), argue that people at the lower end of the socio-economic scale often do not have the resources necessary to make positive changes to their living arrangements, a situation which they contend is “graphically illustrated” by current Maori statistics, both in health and socio-economic indices. In addition to considering the impact of socio-economic variables on health development, Government also needs to take into account the need for quality funding and effective monitoring of outcomes in improving health outcomes. Policy also needs to be adequately resourced and an integrated policy approach by involved policy agencies should be promoted. According to Blank, health policy-making is not amenable to subdivision. Instead, it represents an area where the contextual parameters require a more integrated policy approach (Blank 1994, p.9).

Achieving equity in health

Improving Maori health outcomes has been a priority for successive governments since 1984 and continues to be so moving into the twenty-first century. The early 1990s saw a continuation of the managerialist structure first advocated by the Fourth Labour Government with health service provision still largely regulated by Vote: Health and a desire to restrict Government spending. By 1995/96, however, the policy environment had begun to change and previously dominant structural influences began to be questioned. In 1990, Malcolm et al. were commissioned by the Ministry of Women’s Affairs to write a report on economic and organisational factors in achieving a better future for Maori women. Their recommendations can generally be applied to the health development of most Maori and highlight why health outcomes for the majority of Maori are not improving at a rate commensurate with that of non-Maori. Malcolm et al. suggested that a primary strategy for improving health outcomes for Maori women was through identifying which underlying structural and material differences were causing inequities in health service provision and behavioural terms. They recommended that focusing attention on these structural and material differences would lead to improvements in health outcomes for Maori women (Malcolm et al. 1990, p.6).

Although the report's terms of reference primarily focused on improving outcomes for Maori women, they also help to provide insight into health development for other Maori. The given terms of reference were (Malcolm et al. 1990, p.6):

- providing commentary on the issues raised by Pomare and de Boer (1988) in Hauora: Maori standards of health: a study of the years 1970-1984, relating to the economic factors impacting upon Maori women's health status
- include an economic analysis of the years of life lost as a result of early death due to preventable illness
- include an economic analysis of the costs associated with the preventable causes of admission to hospitals
- include comments on possible strategies which might be adopted to ensure that health resources are targeted more effectively to achieve better health outcomes for Maori women including through primary health care strategies

Although all of these factors play an important role in assessing the impact of policy and sector change on Maori health development throughout the 1990s, it is the second and fourth terms of reference which, in my view, provide valuable insight into the development of health outcomes for Maori during this time. Resource allocation strategies, particularly those focusing on Maori provider development and mainstream service availability, in addition to targeting the economic causes of poor health, have been prioritised in the second half of the decade. This is demonstrated by documents such as 'The Government's Medium Term Strategy for Health and Disability Support Services' in which the Ministry of Health (MOH) sought to target the causes of poor health and to identify ways in which resource allocation could be improved and mainstream responsiveness to Maori increased. This strategy actively seeks to analyse the medium- and long-term effects of policy and looks towards a long-term focus on health. A primary focus of this strategy is to:

“maximise the benefits of early intervention, proper integration of services, health promotion, and the involvement of communities in developing solutions to their health issues” (Ministry of Health 1999f, p.1).

Of the twelve goals expressed by the Ministry of Health which aim to achieve equity in health for all New Zealanders, five are particularly important to the development of equitable health status for Maori. These goals are:

- acknowledging the special relationship between Maori and the Crown;
 - decreasing long-standing disparities in health
 - greater emphasis on population health approaches to improve population health policies to improve overall health outcomes for all New Zealanders, especially those who traditionally have less healthy outcomes
 - intersectoral collaboration between agencies and providers to achieve social policy objectives
 - improved capability and adaptability of the health and disability sector
- (Ministry of Health 1999f, pp.5-6)

The Ministry believes that policies which are designed to benefit people with poor health outcomes, such as Maori, need to be more visible and that people need to become aware of them. Consequently, the Ministry argues that “prioritisation processes and criteria need to be rational, fair, transparent, and nationally consistent” (Ministry of Health 1999f, p.7). An essential part of this process is identifying the causes of poor health. The Ministry’s perspective has shifted from symptomatic to causal and it is now focused on promoting improved health outcomes rather than focusing on outputs, or programmes and policy itself. The Ministry argues that a focus on the “determinants of health, and building and supporting strategic alliances, should assist in shifting the focus onto the fundamental causes of poor health rather than dealing with the consequences” (Ministry of Health, 1999f, p. 11).

Identifying the fundamental causes of poor health for Maori necessitates looking beyond the available statistics. Pomare et al. (1995, p.14) argue that statistics may highlight differences in health status but are of limited use unless there is “informed interpretation” to highlight causes of differences, and to point to remedial action which will impact on these causes and lead to improvements. Reliable data on morbidity and mortality trends for Maori is required in order to assess the impact of policy, resource allocation priorities, health programmes and services, and the cost effectiveness of different intervention strategies. According to the Ministry of Health,

this information needs to be gathered in conjunction with improved policy development and direction (Ministry of Health 1999a, p.50).

Coalition Agreement on Health, 1997

Policy direction for Maori health has tended to reflect a number of the same priorities during the 1990s despite changes to the ascendant political ideology. Whaia te Ora mo te Iwi: Strive for the Good Health of the People, for example, was first published in 1992 in response to Maori issues highlighted in the Health and Disability Services Bill. It was republished in 1993 as the Government's Maori Health Policy statement under the same title, Whaia te Ora mo te Iwi: Maori Health Policy Guidelines to the Regional Health Authorities and the Public Health Commission, proposing three key policy directions for Maori health development. These policy directions were subsequently reflected in the 1997 Coalition Agreement on Health.

In Whaia te Ora mo te Iwi: Strive for the good health of the people (1992), the Department of Health argued that in order to improve health outcomes for Maori there needed to be: greater participation of Maori at all levels of the health sector; resource allocation priorities which take account of Maori health needs and perspectives; and the development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of health services (Department of Health 1992, p.17). In turn, the 1997 Coalition Agreement on Health sought to improve Maori health outcomes by emphasising the need to consolidate Maori provider networks and to build up the professional Maori health workforce. Included among the general policy initiatives of the Agreement was a commitment by Government to improving Maori health by "[increasing] resources . . . available to provide Maori leadership within the health sector, and to enable the continuing growth and development of Maori health service provision by Maori (New Zealand Government 1996, p.?).

Other key developments from the Coalition Agreement on Health were the establishment of four Maori Commissions (education, health, economic development, and employment and training), thus acknowledging the interdependent nature of health and socio-economic development, and the development of the Maori Provider

Development Scheme (MPDS). The role of the Maori Health Commission (MHC) centred on providing advice directly to the Minister of Maori Affairs on how to reduce disparities in terms of health outcomes between Maori and non-Maori. The objectives of the MHC included acting as a “think tank” for new initiatives to accelerate Maori health development, and managing the expectations of Maori communities, sector agencies, and the public (Ministry of Health 1999e, p.21).

By comparison, the strategic objectives of the Maori Provider Development Scheme (MPDS), which was to remain in place until June 2000, were to (Ministry of Health 1999e, p.20):

- accelerate and improve Maori health and disability workforce development
- improve the quality, accessibility and appropriateness of health and disability services to Maori
- improve the integration and co-ordination of health and disability services to Maori
- enable Maori health providers to develop more effective health service provision

In its 1999 post-election brief to the Minister of Maori Affairs, Te Puni Kokiri, the Ministry of Maori Development, acknowledged the commitment by Government to the Maori Provider Development Scheme and the integral role played by the MPDS in improving Maori health outcomes. Te Puni Kokiri stated that:

“Government is committed to supporting the MPDS so that Maori capacity to deliver services to Maori is improved. Greater Maori participation within the sector is critical to improve overall Maori health status. This includes the need to focus on workforce development, Maori provider development and alternative purchasing strategies” (Te Puni Kokiri 1999c, p.74).

The 1997 Coalition Agreement on Health also reflected the Maori Health Policy provisions of Ka Awatea (1991), the Government’s key mainstreaming document, and emphasised the following priorities: accelerated development of Maori providers and the Maori health professional workforce; increased public resources for Maori health; a focus on health gains and outcomes; and continued improvements in the

effectiveness of Crown-owned providers (Steering Group 1997, p.54). Ka Awatea was the Government's Maori Affairs policy statement which established mainstreaming as the dominant policy approach. The main focus in this document was on the housing, employment, health and education needs of Maori (Ministry of Health 1999e, p.16). The concept of mainstreaming was developed following the restructuring of the former Ministry of Maori Affairs. Although both the Ministry of Health and Te Puni Kokiri have retained specific areas of statutory responsibility for Maori outcomes in terms of health and socio-economic development, all other government agencies are also responsible for promoting and working to improve outcomes for Maori. Mainstreaming is based on this shared responsibility.

The Ministry of Health has retained responsibility for: strategic planning, policy advice, review, specification and assessment of services, regulation, and management of health funding (Green 1996, p.153). By comparison, Te Puni Kokiri (TPK) has a mandate to address specific socio-economic variables including health, training, economic resource development and education (Te Puni Kokiri 1991, p.73). TPK is also required to review services provided by the Ministry of Health, including reviewing how bicultural initiatives are undertaken by the Ministry in terms of both policy and staff responsiveness. Other government agencies are responsible for the remaining areas of policy not covered by the MOH and TPK. These agencies are expected to be accountable for improved Maori outcomes and to develop policy that is culturally appropriate and transparent.

In terms of improved outcomes for Maori, two key themes emerged from the implementation of the 1997 Coalition Agreement on Health. The Steering Group identified that there was a call for the health sector to have an outcome or health gain focus, and in order for this to occur it was important to: monitor and measure performance against set objectives; change behaviour to improve performance; and develop health measures to reflect outcomes and desired gains (Te Puni Kokiri 1997, p.19). The Steering Group also recognised Treaty of Waitangi obligations on the health sector and called for the sector to recognise these obligations to Maori under the Treaty. The current focus on Maori provider development and culturally appropriate delivery of services to Maori by mainstream health and disability services was also supported (Te Puni Kokiri 1997, p.20).

Relating reform to Maori health development in the 1990s

As stated previously, the process of reform should centre on examining existing policy, assessing why stated objectives are not being achieved, and asking what changes need to be made so that these objectives can be achieved. Saltman and Van Otter (1995, p.4) suggest that health reform needs to be judged on whether the following policy objectives are being achieved: the equitable distribution of services among members of society; assessing the intersectoral impact of reform decisions on housing, employment, and other socio-economic variables that help determine health status; and assessing the impact of reform on the overall health gain of the population. Issues of equity, fairness and optimisation of circumstances also need to be included as part of the reform process and in policy analysis. This thesis is asking two main questions with regards to the impact of health sector reform on Maori health development during the 1990s. First, have the disparities between Maori and non-Maori in terms of health status been exacerbated by health reform during the 1990s? Second, what has been the cost, in health terms for Maori, of the economic and political climate during the last decade?

In terms of assessing Maori health status at the end of the 1990s, conventional indicators of morbidity and mortality provide useful analysis of variance in trends over periods of time, and of the appropriateness and effectiveness of policy and services. After basing an assessment of Maori health at the end of the 1990s on conventional indicators, Reid (1999, pp.89-90) argued that Maori are unable to continue to improve their health status for a number of reasons. These reasons include: fewer health care options; lower levels of access to providers; levels of access to providers in certain rural and isolated areas are often less than required; and a reduced ability of the system to be responsive. Maori can also face other significant barriers in accessing and appropriating effective health care. These barriers include: negative funding based on traditional after-the-event cures; a lack of adequate funding for Maori providers; insufficient resource allocation; and a lack of emphasis on health promotion and education. Other barriers include: a negative statistical comparison with non-Maori; a pejorative perception of the so-called “Maori health problem”; structural difficulties; health workforce attitudes; the cost of health services; inadequate housing; and transport and education issues.

Once these factors are taken into consideration, a grim picture of Maori health development in the 1990s occurs. The gap between Maori and non-Maori is widening not only in terms of life expectancy, but also in terms of socio-economic status, relative income levels, mortality rates, and the onset of chronic illness or disease (Ministry of Health 1997c, p.62). According to Reid (1999, pp.89-90), based on a study of Maori health development from 1970 to 1991 by Pomare et al. (1995), Maori health status in the 1990s can be depicted as:

- higher risk of infectious diseases, including pneumonia, tuberculosis, and rheumatic fever than non-Maori
- higher risk of hospitalisation for, and deaths from, asthma than non-Maori
- increasing rates of suicide and hospital admissions for mental illness
- higher risks of cancers, especially those of the lung, cervix, stomach, liver, and uterus than non-Maori
- higher risk of heart disease, especially coronary, hypertensive, and rheumatic heart disease than non-Maori
- higher risk of diabetes and its complications than non-Maori
- a level of access to primary health care services less than estimated need
- institutional barriers to secondary and/or tertiary care
- lower life expectancy, and life expectancy lived free from disability, than non-Maori
- lower levels of such health determinants as education, housing, income and employment than non-Maori
- higher likelihood of belonging to lower socio-economic groups than non-Maori
- a greater likelihood of living in areas with higher rates of poverty and lower levels of servicing than non-Maori

A number of these issues facing Maori are not new but have not improved as significantly as might have been expected during the last decade given the emphasis placed on health and reform at this time. An inequitable or disproportionate balance still exists between Maori and non-Maori in terms of health status, and is arguably becoming worse. Reid (1999, p.93) argues that Maori health status has regressed

during the 1990s, and that we are “living in the only decade of the twentieth century in which the health of Maori is, by critical measures, not improving, and indeed, is likely to be worsening”. As a result, challenges for Government lie in recognising and developing appropriate strategies to address and reduce barriers to health care for Maori.

This includes designing strategies to improve mainstream responsiveness and increasing the effective of Maori providers. Maori providers have had limited success in improving Maori health outcomes and rates of access to primary care but are hampered by varying strength capabilities, inequitable resource allocation, and a lack of venture capital. The Ministry of Health (1998a, p.7) acknowledges the role played by Maori providers in improving health outcomes for Maori, but believes that Maori health services are too few and too small to improve Maori health outcomes by themselves. The Ministry further believes that mainstream providers would benefit from working with Maori providers to identify viable health options for Maori and how more equitable health gain could be achieved.

At the Third Runanga Kuia in 1993, delegates recommended that Government direction for health gain, such as the establishment of goals, policy changes and programmes, should be negotiated and continually assessed by both policy makers and affected population groups (Te Puni Kokiri 1993d, p.63). In terms of positive Maori development, inclusion of a local perspective in setting policy goals appears necessary for health development and gain at the local level. Strategies and programmes developed by Government need to be seen by local populations as responsive and viable if they are to produce positive results.

Criticism has been made by local Maori of the “policy gap” between Government assessment, or top-down assessment, and day-to-day community needs (Puketapu and Pihema 1999; Robson, Keefe-Ormsby and Rochford 2000). Community participation, as recommended by the Ministry of Health, is seen as essential to an improved health sector; one that is responsive to the local capacity of Maori and other disadvantaged groups to improve and protect population health outcomes. Health promotion and education programmes are an effective first point of contact for Maori and can easily be incorporated within a mainstream context. Health promotion

programmes and population health strategies are generally designed to target those at greatest risk. This was an important issue that emerged from the reformed health sector last decade.

The purpose of this chapter has been to relate the changes in health policy and sector reforms to the development of Maori health over the last decade. In the early- to mid-1990s, Te Urupare Rangapu (1988), Ka Awatea (1991), and Whaia te Ora mo te Iwi: Strive for the Good Health of the People (1992) provided a framework for Maori policy development and the provision of social services for Maori. The policy framework created by these documents centred on three main strategies for improving Maori health: enhanced mainstream capacity to respond to Maori; enabling Maori self-determination and management through devolution of authority; and integrating services to advance Maori socio-economic status and Maori health development (Ministry of Health 1993, p.12). These strategies remain in place.

This thesis seeks to assess the impact of policy change on Maori during the 1990s and to question why Maori health development continues to lag behind that of non-Maori despite the priority status accorded to Maori health as a health gain priority area, especially by the Ministry of Health. The Ministry of Health's priorities for Maori, where Maori health was identified as a health gain priority area, were addressed in Te Puni Kokiri's 1999 brief to the incoming Government (1999c, p.74). This occurred as part of Te Puni Kokiri's mandate to monitor the Ministry of Health's efforts to improve health outcomes for Maori. The Ministry of Health's priorities for Maori include: accelerating Maori participation, accelerating mainstream enhancement, proactive collaboration between mainstream and Maori, and intersectoral collaboration. In addition to these priorities, it is as equally important for Government to identify the main factors which protect and promote good health as it is to develop good quality policy (National Advisory Committee on Health and Disability 1998, p.8).

This thesis seeks to assess Government's response to this issue. Factors which prevent Maori from experiencing improved health outcomes will also be examined. In order to assess what these factors are, this thesis will examine changes to health policy during the 1990s in light of Maori health development, primarily focusing on:

changes in health sector culture; the place of the Treaty of Waitangi in health policy development; mainstreaming as the dominant policy; government policy agencies being held accountable for improved health outcomes for Maori; and the role of institutional influences in determining policy. Implications for the health sector as a result of policy shifts in the 1990s are discussed in addition to repercussions for Maori health development. Chapter two will examine the nature of the policy process, the impact of institutional procedures on this process, and the effect these procedures have had on health policy development during the 1990s.

CHAPTER TWO

Policy development: the role of institutions in determining health policy

Introduction

As discussed in chapter one, reform of the health sector should seek to improve the current system where it is perceived to not be working or where it is less efficient than is desired. The identification of reasons why this is occurring and possible alternatives is a key part of the policy development process. Policy analysis should include: diagnosis of the problem(s) or initiation stage; identification or estimation of alternatives; adoption of a new policy based on these alternatives; implementation; evaluation; and possible termination of the policy (Brewer and deLeon 1983, p.266). In addition to assessing the impact of this process on sector development and health outcomes for Maori, it is also important to assess the role played by institutions in this process. Institutions structure the policy environment by determining which actors are permitted to enter the policy environment, which are not, and by defining procedures for making policy decisions. Institutional structures also create rules regulating the possession and use of political rights and resources (Orr 1997, pp.62-64).

Nuthall argues that institutional barriers are often responsible for distorting or preventing reasonable utilisation of health services for minority populations such as Maori (Nuthall 1992, p.56). Consequently, the aim of this chapter is to detail the policy process, the role played by institutions in this process, and to examine the impact of these processes on policy development in the 1990s. Specifically, this will be done through examining the work of Ellen Immergut on institutional politics and health sector reform in Western Europe. Immergut examined the process of health reform in three West European countries - France, Switzerland, and Sweden - and concluded that although the process of reform undertaken in each of these countries was different, the role played by institutional procedures in each process was significant. These procedures included rules of the game. Within each of these

countries, institutional procedures either enhanced or restricted opportunities for actors to achieve strategic objectives.

Immergut argues that the ability of Governments to impose programmes of reform depends upon the institutional and political framework in which they are operating. She also claims that institutions mediate the impact of other causal factors on the development of welfare state policies. Although these factors are important in themselves, institutions determine how significant the impact of each variable will be (Immergut 1992, pp.5, 231). Under this approach, institutions are viewed as political mediators. This is important in terms of health sector reform and Maori health development during the 1990s. Health development targets for Maori during the 1990s were decided within a political environment that was strongly influenced by causal factors such as economic ideologies and socio-economic objectives. Each process of reform undertaken during the 1990s was mediated to a different extent by these factors.

Immergut's research was selected as the theoretical basis for this thesis as the process of health sector reform in New Zealand from 1990 to 1999 can be interpreted as a product of the institutional environment during the 1990s. For example, Orr (1997, p.89) has interpreted the Health Reforms of 1991 as an attempt to confront the perceived problems of the health sector by redesigning its institutional structure. Moreover, the development of welfare policies and health outcome targets can also be seen as products of this environment. Strengths of this approach, therefore, are: one, it allows room for divergent factors to influence policy outcomes; and two, it acknowledges that institutions help to define policy parameters by influencing the environment in which these parameters develop (Immergut 1992, p.243). By comparison, a weakness of this approach is that institutions are seen as preventing the ascendancy of any one particular factor, such as a strong economic focus, by creating boundaries within which actors make their choices (Immergut 1992, p.242). Consequently, policy outcomes are not seen as the result of exclusive economic or political ideologies as was arguably the case with the Health Reforms of 1991.

The development of public policy

According to Scott, public policy should be concerned with defining the “appropriate role for Government in society and the interface between public and private actions” (Scott 1993, p.2). Public policy can also be divided into separate categories of analysis. These categories centre on the nature of policy and how defined objectives and goals are achieved. For example, descriptive public policy is concerned with examining what is, prescriptive public policy places emphasis on what should be, while regulatory public policy imposes constraints or restrictions on the actions of groups or individuals by providing rules of conduct with sanctions backed up by the authority of Government (Scott 1993, p.248; Blank 1994, pp.1-2).

A further dimension can be added to these categories in an analysis of social policy. Social policy analysis should be concerned not only with the factual description of social situations but also with how disadvantages or advantages arising from these situations are distributed among different groups in society (Cheyne et al. 1997, p. 15). Scott suggests that it is necessary in stating the intention of policy to differentiate between policy intentions and achievements, and between current and future policy direction. Scott argues that policy is seen as an evolutionary process or as a set of interactions among related decisions (Scott 1993, pp.1-2).

Blank supports Scott’s thesis by contending that the estimation stage requires that policy options generated in the initiation stage be further refined so that the consequences of each course of action can be assessed. Blank suggests that the following questions need to be asked during this process: one, what are the likely costs and benefits of each policy option; and two, what groups are most likely to benefit from or to be deprived by each policy option, and to what extent (Blank 1994, p.137)? Cost-benefit analysis needs to identify the differing needs of society, groups and individuals that are affected by policy, and weigh up the costs of each proposal to these actors in relation to the benefits expected. Is the overall cost to each group justified by the expected benefits (Blank 1994, p.9)?

Blank also suggests that the way a particular policy option is framed can significantly affect its impact on various populations within each country (Blank 1994, p.137). It

can also affect local perception of the policy thus determining whether implementation is successful. Unless the public view the new policy as reasonable, implementation will be difficult. This is especially the case where the policy initiative represents a major departure from prevailing policy and threatens established institutional and value structures (Blank 1994, p.138).

Successful implementation relies on accountable and transparent policy objectives that are acceptable to affected populations, and whether implementation is conducted through a top-down or bottom-up approach. Top-down approaches involve policy that is developed and implemented at Government level while bottom-up approaches emphasise local, population-based solutions to problems affecting a community. Bottom-up approaches rely on local execution, usually involving consultation with the targeted community, for successful implementation of policy. Bottom-up approaches also allow communities to exercise a relative degree of independence in developing health standards. As policy by itself is not responsible for bringing about improvement in health outcomes, there needs to be effort at the community and individual levels that consolidates change at the policy level.

Te Puni Kokiri [TPK] argues that the success of any Government strategy depends largely on the “active participation of clients in the designing, development, and resourcing of [those] strategies. The specialist agency should develop management practices that ensure the involvement of clients at every level” (Te Puni Kokiri 1991, p.75). Bottom-up approaches also incorporate a major Government outcome for Maori; Maori are able to fully participate in decision-making. Te Puni Kokiri argues that as *tangata whenua*, Maori must “play a greater role in decision making and in implementing these decisions at a national, regional and local level” (Te Puni Kokiri 1991, p.64).

In determining the impact of health policy on affected populations, it is necessary to evaluate each policy within its specific economic, social, political and cultural context to allow for more effective analysis and evaluation (Palmer and Short 1994, p.29). The definition of what constitutes health policy is also important in this context. Blank defines health policy as consisting of those courses of action proposed or taken by a Government which affect health care institutions, organisations, services and

finance (Blank 1994, p.1). By comparison, Patrick and Erickson (1993) suggest that health policy primarily consists of examining costs and outcomes, and suggest that allocation of health resources also raises larger questions of how society makes social choices and arrangements. They view comparative costs and outcomes as being used in the socio-political process to maximise the welfare of the worst off in society (Patrick and Erickson 1993, p.12).

Palmer and Short (1994) offer a third definition. Palmer and Short argue that health policy direction is determined by both the structural dominance of the medical profession and the policy making process within each society. Health policy embraces courses of action that affect that set of institutions, organisations, and services and funding arrangements called the health care system (Palmer and Short 1994, p.26). Alternatively, Ham and Hill (1984), cited in Palmer and Short (1994), view the principal objective of health policy analysis as being to locate each specific policy within an appropriate economic, political, social and cultural context so as to allow more honest and effective analysis, criticism, implementation and evaluation (Palmer and Short 1994, p.29).

Four particular features of the political environment that are influential in the development of public policy can also be discerned: ideology, international trends and experience, historical and cultural factors, and specific features of the local landscape (Scott 1993, p.3). Specific features of the local landscape can include the institutional structure of Government, and historically based analysis. Orr contends that the latter is important to understanding why and how an actor's preferences and strategies change, and the role of institutions in causing that change (Orr 1997, pp.63-65). The directional shifts experienced in health policy during the 1990s reflect the influence of each of these elements at different points in time. For example, the Health Reforms of 1991 were strongly influenced by the ascendancy of the neo-liberal paradigm in the early years of the decade, while development of health policy, following the signing of the Coalition Agreement on Health (1997), reflected a need to compensate for historical and cultural factors which had led to disproportionate health outcomes for different population groups. It is the influence of institutional structure on policy direction, however, which is particularly important in terms of this thesis in assessing

the development of health policy during the 1990s and the implications for Maori health outcomes.

Institutional influence on policy development

The role of institutions is important in defining the political context, and mediating over which interests will be promoted. Immergut argues that what is seen as politically feasible and promoted within Government depends on the way actors and interests are introduced into the policy context, as much as on “their initial preferences about a particular policy” (Immergut 1992, p.xiii). Institutions structure the policy environment by promoting certain interests over others and by facilitating political entry to some actors. This is important in terms of improved outcomes for Maori as political entry to the system, and participation in the planning and delivery of services are seen as prerequisites to success (Pomare 1988, p.711). Actors and interests are introduced into a structured policy environment via the institutional arrangements of the system. The rules of the game are decided by the institutional structure. In turn, these rules, or procedures for making policy, determine the groups whose views will be represented, and thus “shape demands by changing the strategic environment in which the demands of groups are formulated” (Immergut 1992, p.xiii).

Immergut’s thesis centres on the primary role of institutional structures in facilitating or impeding entry to actors, and the way institutional rules are used to define relevant issues and the policy context. These institutional rules can include independent political variables of: political party organisation, formal and informal institutions for making decisions, and Government’s ability to frame the policy context. Dependent political variables can also exert influence on this process, and these include: existing health and socio-economic policies, economic growth, advances in medical technology, cultural limitations, political ideologies, and whether the “problem” is framed as a public issue (Immergut 1992, pp. 5-10).

In examining the influence of institutions on policy development, it is necessary to establish a definition of what an institution comprises. The study of institutional influence played a dominant role in policy analysis prior to the 1950s, but this analysis was largely limited to comparative studies of political, administrative and

legal structures in various countries. Orr argues that with the onset of the behavioural revolution in the 1950s and 1960s, the emphasis switched from a study of formal institutional structure to one of understanding how the informal distributions of power, and the “attitudes and behaviours of individuals and groups, explained the outcomes of political conflicts” (Orr 1997, p.61). Orr details the development of various schools of thought in relation to policy development, including rational choice theory, and March and Olsen’s (1996) exchange perspective.

Rational choice theory centres on actors’ social and political choices, and argues that these choices are made from a rational, self-interested position in order to produce optimal outcomes (Orr 1997, pp.61-62). March and Olsen’s exchange perspective, by comparison, views politics as the aggregation of individual preferences into collective actions by procedures of negotiation, bargaining, coalition formation and exchange. Having examined these perspectives, Orr concludes that both neglect to examine the role played by institutions in explaining policy outcomes (Orr 1997, pp.61-62). The result of this omission has been the development of an alternative approach to policy outcomes, one which re-emphasises the role of institutions in shaping the goals and strategies of actors, and in influencing the outcomes of political struggles between those actors (Orr 1997, pp.61-62). This thesis argues that these perspectives have limited utility, however, for traditionally disadvantaged groups such as Maori. Such groups are restricted in exercising choice, or in bringing pressure to bear on political procedures, due to limited resources and curbed bargaining power.

March and Olsen (1996), cited in Orr (1997, p.62) have classified this alternative approach as the “institutional perspective”. Orr suggests that problems exist with this approach as the role of institutions in policy development is either minimised or maximised depending on where the primacy of institutional influence is perceived to lie. Two groups dominate this discussion: rational choice institutionalists, and historical institutionalists. As discussed in chapter one, rational choice centres on the ability of the individual to maximise his or her self-interest. Consequently, rational choice institutionalists see institutions not as determining outcomes for individual actors, but as political variables capable of shaping options and choices. By comparison, historical institutionalists perceive the influence of institutions to be primary, and that the “choices, strategies and goals of individuals and groups” are

shaped by this influence (Orr 1997, p.63). This approach centres on the rules of the game that structure interactions between individuals and groups (Orr 1997, p.63). Is the goal of this approach, however, to emphasise the interactions between various actors or to examine the influence of political structures in policy development, and how do we decide which influence has ascendancy?

For example, the institutional definition offered by Hall (1986), and adopted by Orr, views institutions as the: “formal rules, compliance procedures, and standard operating procedures that structure the relationship between individuals in various units of the polity and economy” (Orr 1997, p.65). For the purposes of this thesis, however, Immergut’s definition of institutional influence will be employed. In analysing the development of health politics in Western Europe, Immergut examines the role of institutional rules, and argues that as actors’ demands are constantly changing, the policy process should concentrate “more explicitly on the procedures for making policy and less exclusively on the demands themselves, although demands never disappear altogether” (Immergut 1992, p.xiii).

Institutional rules do not determine policy outcomes themselves, but influence the policy process by linking specific decision makers, or by allowing them more or less independence of action (Immergut 1992, p.27). These rules and procedures are dominated by the institutional structure of Government, and policy outcomes are dependent on which groups are let into the policy making process by the institutions, specifically, the State. Immergut argues that if you do not pay attention to political institutions, then social variables are divorced from the political context that gives them meaning (Immergut 1992, p.19). Immergut argues that institutions explain policy outcomes:

“ . . . precisely because they facilitate or impede the entry of different groups into the policy making process. Different procedures for making policy decisions frame policy debates: They change the array of actors that are brought into the decision-making process, and they provide distinct sets of advantages and disadvantages to groups wishing to promote their interests” (Immergut 1992, p.xii).

Immergut further argues that institutions shape the interests and demands of groups involved in the policy making process by changing the policy environment in which the demands of groups are formulated (Immergut 1992, pp.xii-xiii). Despite Immergut's primary thesis of institutional, or State, control of the policy process and the development of social outcomes, she also acknowledges that certain groups, such as the medical profession, enjoy an amount of autonomous control of this process. One result of this autonomy is that they are able to move decisions out of the political sphere, the State or the market, depending on which environment best suits their current demands and goals (Immergut 1992, p.16). Through this autonomy, they are also able to influence the development of health objectives for certain population groups. This is important in terms of Maori health development and will be discussed further in chapter five.

Consequently, the ability of the institutional structure to influence actors, and through such influence shape policy, is limited. The role played by institutions, and their influence over actors in the policy process, is not strictly defined and inflexible. Immergut (1992), cited in Orr (1997, p.66), argues that political decisions are not single decisions made at any one point in time, but are instead comprised of a sequence of decisions made by different actors at varying institutional locations. Immergut claims that there is no:

“linear relationship between a specific set of political institutions and the interest group that will succeed, or the health system that results. For, whereas the structures of decision making provide incentives for actors to act as they do, and therefore help to account for the choices that they have made, the freedom to choose remains in the hands of these actors” (Immergut 1992, p.xiv).

Immergut also looked at the political environment as a whole to explain why policy development occurs in certain ways. Political systems need to be viewed as a whole in order to ascertain whether or not actors' actions make sense. Immergut sees this as comprising an environment of conduct, or an institutional configuration. Without a policy framework and an understanding of the policy process, actors' actions do not make sense. The institutional environment provides a frame of reference for such actions (Immergut 1992, p.28). Political institutions can also allow actors within a

system to define their own courses of action and ideology in addition to creating an environment in which actors and variables can gain meaning. Policy shifts are not formed at any one particular instance in time or by any one set of variables, but are mediated by the role played by political institutions, particularly that played by the State. Institutions are responsible for ordering the preferences of actors that are reflected in policy, and the omission of others. Institutional rules allow these demands to become visible and politically significant (Immergut 1992, p.21).

Immergut argues that by providing rules for adjudicating amongst different groups, institutions privilege some groups and interests at the expense of others (Immergut 1992, p.21). Institutions provide actors with opportunities and means through which to enact their preferences while maintaining a relative measure of constraint.

Institutions can also be responsible for altering the political landscape and limiting the amount of influence exerted by each group. Moreover, institutions help to define policy options by: changing the array of actors pertinent to each policy decision; altering the relative importance of these groups; and redefining the political alternatives (Immergut 1992, pp.229-231). Within this institutional environment, historically based analysis is acknowledged as important. Time helps to explain why actors develop particular goals, and why they favour some goals over others (Orr 1992, p.65). This is a key premise of historical institutionalism. Immergut suggests that the importance of historically based policy is vital to understanding why certain power inequalities exist among actors (Immergut 1992, p.28). Historically based analysis can also help to determine whether health policy objectives for population groups, such as Maori, are being achieved.

Common approaches in comparable nations are also identified as important in developing health policy. These approaches include the economic growth paradigm, and the cultural limitation paradigm. The economic growth paradigm centres on the importance of economic growth and technological progress in the development of health policy. Given that these factors are often thought to provide definite policy parameters, there seems little opportunity for other variables to influence policy direction. In contrast, the cultural limitation paradigm looks to the significance of cultural traditions, policy legacies, and ideological arguments for setting health policy parameters. Particular emphasis is placed on distinct national traditions, and the

strength of liberal ideology (Immergut 1992, p.10). This is important in terms of promoting health gain for Maori. The influence of cultural traditions and policy legacies on health outcomes for Maori will be discussed in chapters three and five.

Having examined these alternatives, Immergut suggests that implementing the cultural limitation paradigm in policy development may prove as limiting as implementing the economic growth paradigm, as policies set in place to solve similar problems in other countries may be limited by ideological or cultural conceptions (Immergut 1992, p.10). Health reform mechanisms employed in one country may prove ineffective in another due to the nature of the structural, institutional, ideological and socio-economic variables involved in each process. This position was supported in a 1992 report from the Organisation for Economic Co-operation and Development (OECD), cited in Blank (1994, p.82), where it was argued that, as with other aspects of health policy, the approach that a particular Government takes is dependent upon both the ideology of past and present Governments, and the predominant models of health care finance and delivery.

Designing an appropriate infrastructure for the health sector is important in determining the specific roles of institutional interests. Major policy shifts in New Zealand health policy since the 1980s, and particularly in the 1990s, affirm Immergut's thesis. Health policy change in New Zealand has often been determined by the nature of the institutional environment in which it takes place. In particular, restructuring of the New Zealand health sector in the early 1990s can partly be seen as a result of institutional influence. As a result of the ascendancy of the economic growth paradigm during this time, the options of some actors within the system have been limited. The ascendancy of this paradigm can arguably be seen to have restricted the options of traditionally disadvantaged groups, such as Maori and those in low socio-economic brackets.

Implications for health policy development from institutional shifts

Prior to 1991, a number of major policy shifts occurred in the health sector, most of which explored the option of making changes to the Social Security Act of 1938. In particular, the Third Labour Government's White Paper of 1974, A Health Service for

New Zealand, examined this possibility. Changes to the Social Security Act did not occur, however, until the 1983 Budget. The 1983 National Government Budget introduced a population-based funding mechanism for allocating resources to hospital boards, in addition to capped hospital budgets. This was the first of five major policy shifts between 1983 and the year 2000, and resulted in the creation of fourteen Area Health Boards (AHBs) from twenty-seven Hospital Boards (HBs) by 1989. Blank argues that the passing of the Area Health Boards Act (1983) resulted from a perceived need for change in the health sector in the wake of: “fragmentation of the system, cumbersome hospital management systems, weak accountability mechanisms, increased hospital expenditures, and lengthened waiting lists” (Blank 1994, p.124).

The Third Labour Government’s White Paper of 1974, in contrast with the eventual move to Area Health Boards under the 1983 Budget, resulted from the economic crisis of the mid-1970s and rising health costs. There was a perceived need for health policy to be regulated and administered at the local level, instead of by central government. The White Paper - ‘A Health Service for New Zealand’ - explored options for cost containment, and recommended that fourteen Regional Health Authorities (RHAs) be established to provide primary and secondary health care services (Cheyne et al. 1997, p.223). Although never implemented due to reasons of political expediency, Boston (1991) sees the White Paper as being of crucial importance to an understanding of later reforms. The Paper identified the need to rationalise New Zealand’s ‘mixed’ system which had existed since the passing of the Social Security Act in 1938, and recommended that fourteen Regional Health Authorities be created to try to overcome endemic fragmentation within the system (Boston 1991, p.278). Although the White Paper recommended the establishment of RHAs, Government opted instead in the mid-1980s for an Area Health Board format in order to promote accountability and health gain, and to control expenditure (Ashton 1992, p.150).

The dualism within the health sector that the Social Security Act (1938) attempted to address consisted of two health systems, the public and the private. The Social Security Act provided for free inpatient hospital care, and this was followed in the 1940s by the introduction of universal subsidies for general practice and other medical services. Ashton (1992), cited in Blank (1994, p.123), argues that by 1947, the “thrust

to put a universal, and pre-dominantly tax-funded, public health service into place was largely completed, although new subsidies continued to be added in later years on an ad hoc basis". Additionally, Fraser states that although Government sought to integrate the health system through the Social Security Act, this did not occur due to the power of the medical profession (Fraser 1984, p.62). Following the passing of the 1938 Social Security Act, the medical profession continued to occupy a position of strength and dominance in the new health sector, as evidenced by the battle over the General Medical Services Benefit (GMSB).

Consequently, a pragmatic approach to accommodate the existence of the private health sector was adopted. Development of the Social Security Act has been interpreted as a compromise between the two factions. This compromise was to prove expensive in later years as the Government's share of health care funding continued to rise, and the real value of the General Medical Services Benefit decreased substantially. Although between 1970 and 1980, Government spending on health increased from 5.1 percent to 7.2 percent, access to primary care became restricted as a result of a decrease in the real value of the GMSB from around 75 percent of the total fee to less than 20 percent (Ashton 1992, p.149). This restriction is evident in the rates of access to primary care by Maori, as noted by Crengle, cited in McLoughlin (1996), and Pomare et al. (1995). Maori tend to access primary services at a later point than non-Maori, and usually at crisis point. According to this evidence, a decrease in the real value of the GMSB arguably contributed to deteriorating health outcomes for Maori.

Reform of the New Zealand Health Sector From 1984 to 1997

With the defeat of the National Government in 1984, the Fourth Labour Government swept to power and began an extensive programme of State and economic restructuring. Orr argues that this programme of reform was necessitated by a severe fiscal crisis, and an urgent need to improve the country's economic performance which had stagnated under the policies of the previous National Government (Orr 1997, pp.79-80). This restructuring programme included examining options for reform of the health sector. The neo-liberal agenda adopted by this Government reflected a desire to reduce State spending on social policy, including health

provision. Cheyne et al. argue that with the State not only funding but also providing health care, there was not the scope for efficiency in service provision that the Treasury believed was possible when services were devolved to providers who competed for delivery of services (Cheyne et al. 1997, p.224). In its post-election brief to the Government in 1987, Government Management, cited in Orr (1997, p.85), Treasury argued that:

“so long as the State is a major purchaser of health care, there seem to be advantages in separating the purchase of health care from the production of hospital or other services. The present amalgamation of functions causes confusions of roles. Equity goals and efficiency targets are forever entangled”.

Among possible options for health reform were recommendations from two reviews of the health sector commissioned by the Government: Choices for Health Care: report of the Health Benefits Review (1986), and “Unshackling the Hospitals” (1988), generally referred to as the Gibbs’ Report, later reformatted as the basis of Simon Upton’s Green and White Paper, Your Health and the Public Health (1991). The Health Benefits Review was commissioned by the Government in 1986. Its terms of reference included reporting on the underlying rationale for State involvement in health, and to recommend broad principles and directions for reform (Scott et al. 1986, p.1). The Review outlined five broad structural options for reform of the health system, expressing a preference for Option 4(b). This option saw the State retained as the dominant funder of health services while introducing more competition for health services provision into the system (Orr 1997, p.82).

Under this system, boards would establish “rational priorities and plans by researching needs, [conducting] discussions at the local community level, and negotiations with a range of private, voluntary and public providers” (Scott et al. 1986, p.111). The report of the Hospital and Related Services Taskforce, “Unshackling the Hospitals”, was also commissioned by the Fourth Labour Government to assess the structure of public hospital administration in New Zealand. Although the Fourth Labour Government rejected the Taskforce’s recommendations, they were subsequently adopted by the new National Government as the basis for the 1991 Health Reforms (Blank 1994, p.125). This programme of restructuring had

health and socio-economic repercussions for Maori which will be discussed in more depth in chapter four.

The 1988 Taskforce recommended that six Regional Health Authorities (RHAs) be established which would be responsible for determining regional health needs, and that those needs should, in turn, be met by public, private, or voluntary agencies whose services would be contracted by each RHA on the basis of quality and value for money (Blank 1994, p.125). The Taskforce proposed that RHAs would be run more like the boards of public companies which would enable them to concentrate on running efficient services. They would be helped in this objective by the new payment structure of user charges for health services which would give them an objective value of the services provided (Blank 1994, p.125). The Taskforce argued that these prices would “drive signals through the system, causing rapid improvements in resource use and clinical practice” (Blank 1994, p.125). Orr (1997, p.91) argues that Area Health Boards [AHBs] were seen to be operating in a policy framework that placed too many constraints on the way they used their resources. Moreover, AHBs were only offered weak incentives for them to use their resources efficiently.

The Taskforce also recommended introducing a purchaser/provider split to avoid provider capture of the system while retaining bureaucratic control by central Government. Orr defines provider capture as a situation where “those who supply state-provided services pursue their own interests at the expense of the interests of the consumer” (Orr 1997, pp.79-80). Different types of capture include market capture, middle-class capture, and Crown-provider capture, all of which are recognised as related economic pressures (Orr 1997, pp.79-80). Under the new system, public hospitals, reformatted as Crown Health Enterprises (CHEs), were retained as providers with Regional Health Authorities acting as providers, or funders.

The new structure was arguably designed to prevent capture of the system by traditional interests, and so allow Regional Health Authorities to make the difficult rationing decisions that Area Health Boards were seen to be incapable of (Orr 1997, p.95). The main problem experienced with the hospital system, according to Orr (1997), was that the system was inflexible, unresponsive, and inefficient. The length

of waiting lists and low morale were also cited as areas of concern requiring prompt attention. The 1988 Gibbs' Report, cited in Orr (1997, pp.82-83), condemned a lack of adequate management information in the system, claiming that the result was "a lack of cost consciousness which undermined the efficient allocation of resources in the hospital system".

In 1991, Scott argued that the National Government's reform of the health sector had the capacity to bring about significant improvements in the efficiency of the health care system despite higher administrative costs. Scott maintained that these gains would come from "greater policy clarity", and a more rational basis for selecting treatments, including a shift to community care, and to more appropriate health care providers (Scott 1991, p.24). However, in spite of apparently utilitarian objectives, such as shifts to more appropriate health care providers, health policy developed in this political climate without consideration of the broader societal context. Boston argues that any theory which ignores "broader contextual factors, social relations and societal commitments is at best incomplete, and at worst is misleading and damaging" (Boston 1991, p.13).

In a report on the feasibility of applying a market structure to health sector reform, Sir John Scott, Chairman of the Clinical Advisory Group of the Crown Company Monitoring Advisory Unit (CCMAU), supported Boston's argument. Scott, cited in Coney (1997, p.150), argued that neo-liberal reform of the health sector is inappropriate because:

"Concepts of competition for funding, purchasing and providing are seen as having been superimposed hastily by people who did not take the time or show the understanding necessary to appreciate how and why people behave and operate in New Zealand private and public health services. This lack of clarity has intensified inequalities of provision and access . . . The frightening mess which has resulted from poorly conceived and poorly drafted legislation must be addressed promptly and with vigour" (Coney 1997, p.150).

As a result, Blank (1994, p.136) suggests that before each policy can be adequately framed, the scope and seriousness of the problem must be clarified. In health policy this requires "an understanding of the interaction of health with a host of economic,

social, and cultural factors, in order to provide an integrated policy strategy". In terms of this thesis, policy development and restructuring efforts by Government during the mid- to late-1990s accorded more importance to this interaction than the Reforms of 1991. Durie (1998b, p.41) argues that policy development in the 1990s has been characterised by "uncertain and changing health policies", which has led to uncertainty in health outcomes for population groups. Policy development since 1996/97 has reflected Government's desire to reduce this uncertainty, particularly for Maori and Pacific Island people. In terms of Maori health policy, Government has been working to provide alternative health solutions for Maori that are effective and appropriate, and which reflect the need for an integrated policy strategy. This strategy is focused on: health promotion, accountable and transparent policy, full and proper consultation with Maori, and the appreciation of a need for greater access to primary health care.

If, as Nuthall (1992, p.56) contends, institutional barriers are often responsible for distorting or preventing reasonable utilisation of health services for minority populations such as Maori, then a key part of the policy process should be to establish why this is so. Institutional barriers include access to the system, structural arrangements of Government, cost of treatment, levels of provision, and the structure of the health system itself. Additionally, it is important to examine the influence of institutions on this process, and whether this influence is affecting rates of health service utilisation. Institutional structures also create rules regulating the possession and use of political rights and resources (Orr 1997, p.64). Consequently, allowance needs to be made within the evaluation phase of the policy process for assessment of policy outcomes influenced by institutional arrangements. If the principal objective of health policy analysis is to locate policy within an appropriate context so as to allow effective assessment, then Government must examine each of the above factors during the initiation, estimation, and selection phases of the policy process (Palmer and Short 1994, p.29).

The dichotomous nature of policy development in the 1990s reflects the institutional environment in which policy was developed at different points during the decade. The early years of the decade witnessed the effects of a neo-liberal agenda being implemented in policy. This agenda centred on reduced State funding for welfare and

social policy provision, and looked to make the health sector more cost-effective. The resources available for health service provision were to be bolstered by fees from consumers - user charges. This agenda was a key component of the institutional structure of Government. In terms of this agenda, reform of the health sector was seen as necessary to achieve efficiency and to reduce State dependency. Reform processes should centre, however, on examining existing policy, analysing why stated objectives are not being achieved, and asking what changes need to be made so that these objectives can be met. The point of health reform should arguably be to assess which parts of the sector require proactive attention and why.

Reform objectives should focus on: how services are distributed among members of society; the degree to which these services are of equal quality; the intersectoral impact of health reform decisions on housing, employment and other socio-economic variables that help determine health status; and the impact of health reform on the overall health gain of the population (Saltman and Van Otter 1995, p.4). Issues of equity, fairness and optimisation of circumstances also need to be included in policy analysis, and as part of the reform process. Health policy development in New Zealand from the mid-1990s onwards arguably reflected these considerations more closely. Following the Coalition Agreement on Health (1997), the development of health policy reflected a need to compensate for historical and cultural factors which had led to disproportionate health outcomes for specific population groups, including Maori and Pacific Island people. This need is reflected in the designation of Maori health as a Health Gain Priority Area (HGPA). Since the late-1990s, Government has attempted to make advances in areas designated HGPAs by recognising the broader societal and institutional environment in which health status develops. In 1992, Simon Upton, cited in Reid (1999, p.58), stated that the Crown acknowledged, "part of the problem has been the inflexibility of the health system, which has been unable or unwilling, to respond to specific Maori needs".

Policy has also evolved from basing assessment of need on single factor theories, such as the managerialist economic ideology employed in the early- to mid-1990s, to an assessment based on more comprehensive theories that reflect the multifarious nature of New Zealand society. Blank (1994) argues that as health is unequally distributed across social and economic variables that any health policy must be sensitive to these

distributions in society. There need to be multifaceted approaches to health care if we are to achieve anything approaching equality of outcome, and one of the dangers of moving towards a market-oriented health system is that attention to broader contextual influences tends to be downplayed (Blank 1994, p.151). Moves towards improved intersectoral collaboration, however, are indications of a change in policy focus.

This chapter has attempted to demonstrate the effect of institutional arrangements on the policy process, and the impact this has on health sector reform. In terms of health reform, it is important that a cost-benefit analysis is undertaken as part of this process, so that an assessment of need, and analysis of expected impact(s), can be made. Factors which prevent population groups from experiencing improved health outcomes may be identified during this process. It is also important to examine specific features of the political landscape which influence policy development. Cunningham and Durie (1999, pp.251-252) state that there is a drive occurring within the New Zealand health sector to improve health outcomes through more appropriate policy direction.

This is particularly important in terms of improved health outcomes for minority population groups such as Maori. Cunningham and Durie argue that there is a “drive to measure health gain as a result of health sector practice, and or healthy public policy generally. This is coupled with a desire by many to be able to better quantify and qualify health outcomes” (Cunningham and Durie 1999, pp.251-252). The goal of policy development and sector reform should be to produce policy that is appropriate and effective, and which will be supported at the local level. Local solutions for local problems are a viable option not only for improving community health outcomes but also for increasing health responsibility. Chapter three looks at the implications for Maori health development during the 1990s from health sector reform, the desire to promote improved health outcomes for Maori, and the development of more appropriate policy direction. The role of the Treaty of Waitangi in promoting Maori health gain will also be examined.

CHAPTER THREE

Maori Health Development

Introduction

In attempting to assess the impact of policy development and sector change on Maori health outcomes during the 1990s, it is important to define what is meant by “Maori health development”, and to analyse Government responsibility to Maori under the partnership terms established by the Treaty of Waitangi (TOW). Durie (1994) offers the following definition of Maori health development. Maori health development involves Maori defining their own priorities for health and then “weaving a course to realise their collective aspirations” (Durie 1994, p.1). A Treaty perspective can be added to this definition as such a perspective is advocated as being more consistent with meeting the aspirations of Maori to define and control their own health. A Treaty perspective also fits with the World Health Organisation’s (WHO) definition of community health development.

The World Health Organisation, cited by the Ministry of Health (1997), argues that health cannot be divorced from the development of communities, and that these communities should have some sense of control and ownership over the development of their health services (Ministry of Health 1997c, p.47). For Maori, this means that health development cannot be separated from the colonial history of Aotearoa New Zealand in terms of the Treaty of Waitangi. The purpose of this chapter is to examine Maori health development during the 1990s, the factors which have had an impact on this development, and Government’s obligation to foster positive Maori outcomes established by the Treaty of Waitangi.

The Treaty of Waitangi and Maori health development

The Treaty of Waitangi (TOW) has been acknowledged by Government as the founding document of Aotearoa New Zealand and, as such, any discussion of Maori health must start with an interpretation of the Treaty. The Ministry of Health (MOH) argues that securing the place of the Treaty within the health sector is vital to the improvement of Maori health in the medium term, as the development of health

services in New Zealand has been part of “the development of the colonial state and a reaction to the signing of the Treaty of Waitangi” (Ministry of Health 1995b, p.3; Ministry of Health 1997c, p.81). Maori health development is arguably a reaction to these events. The Ministry of Health argues, however, that while Government has acknowledged that the Treaty of Waitangi is the founding document of this country, and that it is the umbrella for articulating and progressing Maori perspectives on health, there is as yet no comprehensive policy or legislative statement on the Treaty and how it applies to the health sector (Te Kete Hauora 1995, p.15). Consequently, Te Puni Kokiri argues that a need exists for the Treaty to be recognised as the “framework for development of health services [for Maori] at all levels” (Te Puni Kokiri 1993d, p.21).

Moreover, there currently exists no specific mention of the Treaty in health legislation. This constitutes an historical and contemporary reason for inadequacies in health policy. According to Milroy and Mikaere, clause 6 of the Health and Disability Services Bill, before it was presented to Parliament, contained specific reference to the Treaty: clause 6 required anyone exercising functions granted by the Act to take into account the principles of the Treaty of Waitangi (Milroy and Mikaere 1994, p.186). This clause was subsequently amended, however, as Government considered that the health needs of Maori would be catered for through the implementation of section 8 (e). Milroy and Mikaere argue, however, that section 8(e) represents a denial of the *tangata whenua* status of Maori, as articulated in the Treaty of Waitangi (Milroy and Mikaere 1994, p.186). Section 8(1) of the Health and Disability Services Act states that:

“Before entering into a funding agreement with a purchaser . . . the Minister shall give to the purchaser written notice of the Crown’s objectives in relation to the following matters:

- (e) The special needs of Maori and other particular communities or people for those services (Milroy and Mikaere 1994, p.186).

According to Te Puni Kokiri, many Maori view intergenerational disadvantage as a breach of the Treaty by the Crown (Te Puni Kokiri 1996, p.93). A gap still exists between the nature of the Treaty, and the “translation of its aims into performance indicators, output measures, and actual health gains for Maori” (Durie 1998b, p.95), in

spite of the employment of Treaty frameworks by various policy agencies.

Additionally, differing interpretations of the Treaty over the past two decades have contributed to confusion surrounding the application of the Treaty to social policy.

The Ministry of Health argues that once the position of the Treaty has been secured in the health sector, then a consistent approach to the development of rangatiratanga can be applied (Te Kete Hauora 1995, p.12).

In terms of Maori health development, both the Ministry of Health (MOH) and Te Puni Kokiri (TPK) see the development of rangatiratanga as crucial. Te Puni Kokiri argues that the Crown's duty is to "recognise and support the exercise of rangatiratanga in whatever form this may take" (Te Puni Kokiri 1999d, pp.3-4).

Rangatiratanga centres on the concept of self-management, and the devolution of control over resources to Maori. According to the Ministry of Health, self-management and control over resources are concepts consistent with community health strategies advocated by the World Health Organisation in the Ottawa Charter (Te Kete Hauora 1995, p.12). The application of Treaty principles to the Ottawa Charter will be discussed later in this chapter.

The Department of Health (DOH) was one of the first Government departments to acknowledge the founding nature of the Treaty of Waitangi, and to champion the inclusion and promotion of Treaty principles in social policy. In Whaia te Ora mo te Iwi: Strive for the good health of the people (1992), the DOH acknowledged the primacy of the Treaty to improved outcomes for Maori. The Department stated: "any discussion of Maori health must begin with an acknowledgement of the relationship between the Crown, relevant legislation, and the Treaty of Waitangi" (Department of Health 1992, p.22). Policy development and sector direction since the late-1980s have focused on developing this relationship, and promoting Maori interests in social policy. For example, Te Urupare Rangapu (1988) looked to a partnership between Maori and Government taking into account "Maori structures, Government commitment to the Treaty of Waitangi, and devolution of certain rôles to iwi authorities" (Durie and Parata 1993, p.17).

Three principles have been defined as being integral to this relationship and to the inclusion of Treaty parameters within policy. These principles are: partnership,

protection, and participation. Interpretation of the ‘principle of partnership is particularly important as it may have implications for social policy development and decision-making, implementation of policy, and delivery of services to Maori and their whanau’ (Horsfield and Evans 1988, p.14). The Royal Commission on Social Policy (1988) argued that these principles are vital to the development and implementation of effective social policy. The Royal Commission also viewed the partnership between Maori and the Crown as essential to improving outcomes for Maori. Further principles with possible implications for Treaty interpretation and Maori health development have been identified by Durie (1996), cited in Reid (1999). These principles are: whakapiki tangata (empowerment), whakauranga (integration), and marae Maori (Maori control). Durie argues that these principles would help to guide a Maori-centred approach to Maori health research and to Maori health development. (Reid 1999, p.62).

Durie has described the original nature of the Treaty as being developed, in part, to address the “deleterious consequences of colonisation” (Durie 1998b, p.82). Durie includes a section from Lord Normanby’s ‘Instructions’ to support his argument that Normanby had intended to protect Maori health outcomes under the terms of the Treaty (Durie 1998b, p.82). As early as 1837, concerns had been expressed about the state of Maori health. As a result, Lord Normanby issued a series of instructions that were intended to address poor Maori health outcomes prior to the signing of the Treaty. He requested that this issue be addressed within the context of the Treaty. According to these ‘Instructions’, the acquisition of land by the Crown “ . . . must be confined to such districts as the Natives can alienate without distress or serious inconvenience to themselves” (Durie 1998b, p.82).

Durie argues that Lord Normanby’s ‘Instructions’ sought to promote “social and economic objectives, and policies of positive protection. [There was] a burden on the Crown to ensure that Maori . . . well being was assured” (Durie 1998b, p.82). Active health protection was motivated by concerns about mortality and morbidity rates amongst Maori since colonisation began. These concerns continue to exist. The Crown needs to protect Maori so that they are able to exercise rangatiratanga, and benefit from it. The only limit to this protection is the principle of reasonableness.

This principle recognises that the Crown's resources are limited (Barrett and Connolly-Stone 1998, p.43).

The principle of reasonableness was recognised in the release of Principles for Crown action on the Treaty of Waitangi published by the Department of Justice in 1989.

Although these principles accorded Maori certain rights as *tangata whenua*, they also highlighted the fact that Government needed to be accountable for the interests of the wider New Zealand society, and that Maori interests were not unlimited by this.

These principles allowed room for the Crown to provide active protection for Maori, but significantly, did not suggest partnership. These were Crown principles for Crown action. Despite not mentioning partnership, the Department did state, cited in Ministry of Women's Affairs (1996, p.18), that the Crown has an obligation, under the Treaty, to consult with Maori on issues affecting Maori. These principles were intended as a guideline for departments when negotiating with Maori.

The Department also devoted attention to the *kawangatanga-tino rangatiratanga* interface which examines the differences between the Maori and English texts of the Treaty. The *kawangatanga-tino rangatiratanga* interface involves the debate over whether Maori ceded sovereignty or governance in Article I. The five Crown Principles are (Ministry of Women's Affairs 1993, p.5):

- the principle of Governance - the *kawangatanga* principle
- the principle of self-management - the *rangatiratanga* principle
- the principle of equality
- the principle of reasonable co-operation, and
- the principle of redress

In spite of the release of the Crown's principles for action, policy agencies are nevertheless required to reflect Treaty objectives of partnership, protection and promotion in policy development through appropriate policy direction. The implementation of a Treaty framework is one way these objectives can be achieved. Policy agencies are also required to seek to improve Maori outcomes. However, various agencies employ alternative Treaty frameworks for the interpretation and implementation of Treaty principles in policy. Some agencies employ an article-by-

article basis of interpretation while others, such as Te Puni Kokiri, the Ministry of Maori Development, advocate an approach where the nature and meaning of the Treaty is reflected in policy objectives and strategies. Treaty frameworks interpret the nature and spirit of the Treaty rather than the literal meaning of the separate Articles.

Te Puni Kokiri's Treaty framework centres on six primary goals to assist effective interpretation, and promote implementation of, the Treaty within social policy. The Ministry suggests that the most useful Treaty framework for Government, and policy, is likely to be one that is (Te Puni Kokiri 1999d, p.2):

- true to Maori understandings and perceptions of the Treaty;
- supported by the findings of the courts and the Waitangi Tribunal;
- consistent with Government policy;
- able to inspire insights about the application of the Treaty to current issues;
- based on common justice and good sense rather than the Treaty alone; and
- focused on universal goals of social cohesion and economic growth

The purpose of Te Puni Kokiri's (TPK) framework is to identify the role of the Treaty in the development of policy to benefit Maori people. TPK emphasises the principles of protection and rangatiratanga, and seeks to ensure that the Crown protects and enhances Maori development by protecting and enhancing rangatiratanga. TPK attempts to do this primarily by addressing disparities between Maori and non-Maori (Te Puni Kokiri 1999d, p.8). The purpose statement of Te Puni Kokiri, cited by Durie and Parata (1993, p.37), is to assist in developing "an environment of opportunity and choice for *tangata whenua* consistent with the Treaty of Waitangi". TPK's development role is further defined in terms of its purpose statement, and under section 5 of the Ministry of Maori Development Act (1991). Section 5(a) of the Act stipulates responsibilities that the Ministry needs to meet to be accountable to Maori, and to see increases in levels of Maori attainment with respect to: education, training and employment, health, and economic resource development. Section 5(b) of the Act requires that the Ministry works with, and monitors, other governmental agencies that have a responsibility to, or for Maori, to ensure that services provided are at least adequate (Durie and Parata 1993, p.37).

The main premises of Te Puni Kokiri's Treaty framework are (Te Puni Kokiri 1999d, p.8):

- the purpose of the TOW is the survival and development of the Maori people
- rangatiratanga is the foremost object of the Crown's protection because it is how Maori protect themselves and develop their culture in a Maori way
- by protecting and enhancing rangatiratanga, the Crown will protect and enhance Maori self-development
- protection of the Maori people therefore requires that wealth gaps between Maori and non-Maori be closed
- the Crown's duty to protect rangatiratanga must be balanced against its duty to govern for the benefit of all New Zealanders
- the Treaty and its principles of good faith provide the mechanisms by which a fair, reasonable and practical balance can be achieved

Policy agencies need to determine whether the Crown is acting to guarantee Maori rangatiratanga in terms of health outcomes. Milroy and Mikaere (1994) argue that one way Government can do this is through providing Maori with control over funding of Maori health services. Milroy and Mikaere argue that Maori control over funding of Maori health services is an essential element of rangatiratanga (Milroy and Mikaere 1994, p.193). Additionally, Government needs to determine whether the separate health needs of Maori are being addressed through Treaty frameworks, and across policy agencies (Health Funding Authority 2000, p.5). Government needs to acknowledge and apply the Treaty through policy, and should look to deliver results with an integrated Maori perspective (Health Funding Authority 2000, p.5).

The 1997 Coalition Government also viewed the partnership between Maori and the Crown as fundamental to improved social outcomes. Taking this relationship as a starting point, the Statement of General Direction, issued by the Coalition Government on Maori Health, displayed a strong level of commitment by Government to improving the level of Maori participation within the sector. Government argued that improved levels of participation within the health sector could help Maori to achieve "full and active participation within the sector" (New

Zealand Government 1996, p.unknown). The Statement of General Direction argued that Maori possess the skills necessary to determine their own social and economic development, and that improvement to socio-economic and health status would come about through the application of justice, equity, and the settlement of Treaty claims (New Zealand Government 1996, p.unknown). Partnership and participation are seen as vital to understanding health and sickness, and in the delivery of health services (Durie 1989, p.284).

Application of the Treaty was also integral to the 1998 Health Funding Authority's (HFA) Maori Health Statement. This Statement centred on the principles of: partnership, proactive protection of Maori health interests, co-operation, and good faith between the Treaty partners (Health Funding Authority 1998a, p.4). The Health Funding Authority required that these principles be evident in all contracts between the HFA and contracted service providers. The HFA also required that "all providers demonstrate how their policies and practices shall benefit their Maori clientele" (Health Funding Authority 1998a, p.4). A main premise of the HFA's Maori Health Statement maintained that as a Crown agency, the HFA considered "the Treaty of Waitangi principles of partnership, proactive protection of Maori health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which the internal organisation of the HFA responds to Maori health issues" (Health Funding Authority 1998a, p.4). The HFA argued that:

"Maori health is a specifically identified health gain priority area (HGPA). The provider will therefore establish a Maori Health Policy that reflects that fact. In developing this policy, the Provider will take into account the Purchaser's strategic direction for Maori health in terms of minimum requirements for Maori health based on the Treaty of Waitangi, Crown objectives for Maori health and specific requirements negotiated from time to time with the Purchaser" (Health Funding Authority 1998a, p.4).

Protection of Maori health outcomes is usually discussed under Article III of the Treaty of Waitangi which promotes citizenship rights and protection in both the English and Maori texts of the Treaty. The Articles of the Treaty in English and Maori are detailed in Table 1. According to the Ministry of Health, the Crown's commitment to improving Maori health outcomes is seen as a reflection of its

reaffirmed commitment to Article III of the Treaty (Ministry of Health 1999a, p.87). Article III reflects issues of equity and rights of citizenship. Under the provisions of the Treaty, Maori health needs are catered for twice: both as *tangata whenua*, and as citizens of New Zealand. In terms of positive health outcomes, Article III is seen as important. Article III-based arguments suggest that under the terms of the Treaty, the Crown is required to recognise the differences that exist between Maori and non-Maori. Under this interpretation of Article III, Barrett and Connolly-Stone argue that the Crown is required to identify disparities between Maori and non-Maori, and to attempt to address them to “the best of its current capability” (Barrett and Connolly-Stone 1998, p.33).

Table 1: Treaty of Waitangi Provisions

	Article I	Article II	Article III
English text	Crown sovereignty	Tribal property rights	Royal protection and citizenship rights
Maori text	Crown authority to govern	Tribal authority over cultural and social resources	Royal protection and citizenship rights
Twentieth century implications	Parliament’s right and authority to govern	Tribal rights to exercise <i>tinio rangatiratanga</i>	Maori right to expect a fair share of society’s benefits

Source: Durie, Whaiaora: Maori Health Development, Second edition 1998b, p.84

Article III not only requires the Crown to be proactive in seeking to reduce disparities between Maori and non-Maori, it also acknowledges that Maori must be proactive in improving their own health outcomes (Ministerial Advisory Committee on Maori Health 1990, p.8). According to the Ministerial Advisory Committee on Maori Health (1990), Article III is concerned with promoting equitable outcomes for all Maori. The Committee proposed that Government view Article III in light of how to generate positive health outcomes by, and for Maori, through its application. The Committee also promoted active protection, and argued that there is an expectation within Article III that “positive, proactive steps will be taken to ensure the maintenance of good health” (Ministerial Advisory Committee on Maori Health 1990, p.8). A key recommendation made by the Committee was that Area Health Boards (AHBs), and subsequent forms of health administrators, need to collaborate with iwi authorities

regarding health policies and health planning, and “seek opportunities for mutually beneficial relationships” (Ministerial Advisory Committee on Maori Health 1990, p.16). However, although the Crown has reaffirmed its commitment to Article III, it does not accept the definition of health as a *taonga*, or treasure, under Article II. Article II has sometimes been interpreted as meaning the Crown has a responsibility to protect the health of Maori over and above the health of other New Zealanders. The Crown does not accept this argument.

According to Barrett and Connolly-Stone (1998), the courts and the Waitangi Tribunal have identified other principles regarding the nature of the partnership established by the Treaty, and resulting obligations on the Crown. These principles are: one, the Treaty established a partnership, and the Treaty partners are under a duty to act reasonably and in good faith with one another; and two, the Crown has a duty to take positive action to protect the rights of Maori including the promotion and protection of rangatiratanga over taonga (Barrett and Connolly-Stone 1998, p.35). These principles reflect the concept of “active protection” endorsed by the Waitangi Tribunal. Active protection is a proactive approach to health development that endorses health promotion and preventative strategies. The Tribunal argues that the “Crown or its agencies [need to] adopt a proactive approach to ensure that Maori well being is enhanced whenever possible” (Te Kete Hauora 1998, p.7). As policy approaches, active protection and health promotion reflect the emphasis of the Ottawa Charter, and the right of communities to develop their own health outcomes. Protection means ensuring the right and ability of Maori to live and develop as Maori (Te Puni Kokiri 1999d, pp.8-9).

The Ottawa Charter: Treaty of Waitangi implications

The World Health Organisation’s Ottawa Charter (1987) consists of five themes that advocate health promotion. The WHO sees these themes as vital to improving the public health of a population. Health promotion is defined by the WHO as the “process of enabling individuals and communities to increase control over and improve their health” (Ministry of Health 1997b, p.6). The Ministry of Health views health promotion policies as important to Maori aspirations to control their own outcomes. Health promotion programmes, and population health strategies, can be

employed to target those at risk. Consequently, a return to the parameters of the Ottawa Charter which emphasise health promotion, public health approaches, and primary and preventative health care has been seen in the development of New Zealand health policy over the course of the 1990s. According to the, then, Public Health Commission (PHC), cited by the Ministry of Health (1997), the approach taken in the Ottawa Charter by the WHO is that health development cannot be separated from the overall development of communities. The WHO argues that these communities should have “some sense of ownership and control over the development of their health services” (Ministry of Health 1997, p.47).

Messiter (1995), cited in Ministry of Health (1997b, p.6), offers the following interpretation of the Ottawa Charter from a Treaty of Waitangi (TOW) perspective. In offering this perspective, Messiter’s objective is to indicate ways in which Maori health outcomes could be improved through cementing the partnership/protection relationship established by the TOW, and subsequently, through the development of healthy public policy. Messiter argues that there is concern amongst Maori that implementation of the Ottawa Charter will supercede the place of the Treaty. Consequently, Messiter has adapted the Charter to reflect a Treaty perspective which works with recent policy, and which reflects the Government’s commitment to Maori health as a health gain priority area. The objective here is similar to the active protection approach adopted by the Waitangi Tribunal. Maori well being should be enhanced whenever possible.

Messiter suggests that the Ottawa Charter be interpreted to enhance Maori health development in the following manner (Ministry of Health 1997b, p.6):

- Developing healthy public policy: Maori health receives top priority from a Treaty of Waitangi perspective
- Creating supportive social environments: recognising and acting on Maori health concepts and practices
- Strengthening community action: iwi Maori having control over their own health and being supported in this through equitable access to health resources and the health dollar

- Developing personal skills: facilitating empowerment through equitable access to training and education
- Reorienting the health system: providing health services for iwi Maori by iwi

Developing healthy public policy is important in terms of improving Maori health outcomes and promoting positive Maori development. Te Kete Hauora (TKH), the Maori Health Group of the Ministry of Health, has developed six strategic long-term goals which reflect the provisions of the Ottawa Charter from a Treaty perspective. These goals are to be in place from 1995 to 2005, and will drive policy development and service provision for Maori. The second of these goals, enhancing healthy public policy, examines the impact of socio-economic variables on Maori health development. Socio-economic determinants of health are discussed in more depth in chapter four. Te Kete Hauora argues that, in practice, effective public policy means that when policy decisions are made, they take into account the impact on the health of whanau, hapu, and iwi. TKH suggests that the following factors should be considered in the development of public policy (Te Kete Hauora 1995, p.12):

- cultural and spiritual well-being
- an adequate income
- decent housing
- healthy food and healthy lifestyles
- safe and meaningful work
- good relationships and access to whanau, hapu, and iwi support systems
- a fair sharing of resources
- many other material, psychological, and spiritual aspects of Maori living circumstances and experiences

The other goals look to promote positive Maori health development through the: promotion of rangatiratanga, maintenance of supportive environments, facilitation of community action, strengthening of individual and whanau skills, and reorientation of health services. The fourth strategic goal developed by Te Kete Hauora can also be seen as integral to positive health development for Maori. This goal focuses on facilitating community action, and seeks local solutions to local problems (Te Kete

Hauora 1995, pp.12-13). Since the late-1980s, successive Governments have emphasised the importance of local solutions to local problems. The Department of Health argued that the emphasis at the local level should be on “balancing resources in relation to local community needs, and planning to link into national or regional guidelines” (National Health Statistics Centre 1989, p.12). Two successive National Ministers of Health also advocated this notion of local solutions for local problems in the late-1990s. Both Bill English and Wyatt Creech viewed this approach as a viable option for improving health development for marginalised groups, and for increasing health responsibility (Douglas 1999).

Te Kete Hauora regards the ability of whanau, hapu and iwi to organise around, and act upon, the physical and social environments as critical to improving Maori health over the long term. The important principles involved here are that Maori have the right and ability to define their own health problems, and that the health sector has a responsibility to work towards solutions with Maori communities (Te Kete Hauora 1995, p.13). Thus, Te Kete Hauora acts as a catalyst to enhance the way the Ministry of Health and the health sector respond to Maori health needs. Te Kete Hauora focuses on leading and influencing the strategic direction and development of Maori health services, and improving the health status of Maori (Ministry of Health 1995b, p.8).

Te Kete Hauora is looking to develop an understanding between Government and Maori of the place of the TOW in the improvement of Maori health. To this end, TKH is committed to establishing an effective Maori health framework to guide policy development and service delivery, and to making resource allocation decisions that provide opportunities for the effective purchase of health services for Maori. A related goal for TKH is to produce quality Maori policy advice as a key part of the Ministry’s core business (Te Kete Hauora 1995, pp.18-19). TKH is also committed to leading and influencing the “strategic direction of Maori health by providing informed policy advice to Government, and ensuring that the MOH meets its obligations to Maori as embodied in the TOW, in order to improve Maori health” (Te Kete Hauora 1995, p.18). TKH argues that there are particular Maori aspects to most policy decisions which necessitate the development of quality Maori policy advice.

Additionally, there are particular Maori policies of a strategic nature that relate only to Maori as Treaty partners (Te Kete Hauora 1995, p.16).

Government efforts to improve health outcomes for Maori

The Decade of Maori Health and Development, announced at the Hui Taumata, the Maori Economic Summit (1984), came to a close at the Hui Te Ara Ahu Whakamua in 1994. Three important recommendations regarding policy, Maori health development, and a Maori development approach emerged from the Hui Taumata (1984). Delegates sought to reduce the disproportionate health balance, as discussed in chapter four, between Maori and non-Maori through the implementation of specific initiatives. Delegates recommended that: the concept of tino rangatiratanga necessitated greater utilisation of existing tribal structures; prevention was promoted over seeking complete cures; and an integrated approach to Maori health was sought. Delegates also recommended that funding be used for health education and promotion to prevent the onset of illness and disease, rather than for traditional after-the-event services (Public Health Commission 1995c, p.7).

At the close of the Decade of Maori Health and Development in 1994, delegates at the Hui Te Ara Ahu Whakamua (1994) made a number of recommendations that focused more closely on policy development. Delegates saw health policy as a key factor in reinforcing healthy lifestyles. Effective policy development and implementation were seen as crucial to improved health outcomes for Maori. Delegates also identified that developing a more integrated and responsive mainstream health sector was integral to improving health outcomes for Maori. They consequently recommended that policy should (Te Puni Kokiri 1994b, pp.5-6):

- be developed by Maori for Maori
- be based on consultation and good information
- raise the status of te reo and tikanga Maori
- ensure access on an equal basis
- promote the unique qualities and talents of Maori

Delegates also asked the Government to be more responsive to Maori and to contribute to Maori health status by: being accountable to Maori; clearly defining

respective roles and responsibilities through Maori resource development; and creating a “level playing field so that Maori can compete on equal terms” (Te Puni Kokiri 1994b, pp.5-6). Flexibility was also targeted as an important feature of the policy process, with an emphasis on a positive Maori development approach. At the Hui, delegates asked of Government, how could governmental agencies contribute to Maori health? Delegates suggested that the answer was Government could contribute to Maori health by:

“handing resources over to Maori, working together . . . to define clearly their respective roles and relationships, increasing the involvement of Maori in their operations, by accepting more accountability, and by improved communication” (Ministry of Health 1997, p.40).

Delegates at the Third Runanga Kuia (1993) also recommended that Government involve Maori in setting Maori health priorities (Te Puni Kokiri 1993d, p.57). This recommendation was reflected in initiatives by Regional Health Authorities (RHAs), and in Government frameworks to cater for the diverse needs of Maori. Two of these frameworks, He Taura Tieke, and the Rangatira framework, have assumed a central importance in the development of Maori health policy. The Rangatira framework resulted from a suggestion by the Steering Group to Oversee Health and Disability Changes, following the implementation of the 1997 Coalition Agreement on Health, that a new Maori policy framework be created to ensure that Maori health needs were met in the new sector. The components of the framework are detailed in Table 2. This shows nine themes and related issues that have been developed by Government to improve health gain for Maori. Cunningham and Durie (1999, p.251) argue that two of the themes are particularly important in terms of positive Maori development: access to mainstream services, and integration - both intra- and inter-sectorally. Maori who choose to access mainstream services may do so for several reasons. These include: a lack of identity with more traditional structures such as iwi and tribal bases, and a lack of comprehensive iwi providers in their area.

The Rangatira framework highlights the need for policy agencies to integrate both externally and internally, and to foster improved levels of health development for Maori. This approach has been cultivated since the early- to mid-1990s by Te Puni Kokiri, the Ministry of Health, and the Ministry of Women’s Affairs. In terms of the

framework's parameters, the desire exists not only to measure outcomes, but to also develop outcome measures that are appropriate for, and relevant to, Maori (Cunningham and Durie 1999, p.251). Cunningham and Durie suggest that intra-ethnic differences amongst Maori, such as urban-rural differences, in terms of health status may be just as great or greater than inter-ethnic differences between Maori and non-Maori (Cunningham and Durie 1999, p.253). This argument was supported by an earlier analysis of Maori health development by Durie (1994). Durie argued that contemporary Maori live in several realities, and that this can lead to disproportionate health outcomes. According to Durie, most Maori are: "significantly disadvantaged on socio-economic indices, are culturally impoverished, and unable to maintain a single Maori identity. All of these factors have implications for health services, and strategic directions for Maori development" (Durie 1994, p.167).

Table 2: The Rangatira Framework

<u>Theme</u>	<u>Issues</u>
1. Rangatiratanga	Treaty of Waitangi Autonomy and self-determination Maori control of service delivery to Maori
2. Access to quality mainstream services	Mainstream services need to be safe, Culturally effective, appropriate and equitable
3. New and existing Maori providers	Not-for-profit services provided by Maori Extension of range of services provided by Maori and active Maori health workforce development
4. Gains and outcomes	Appropriate measures for monitoring progress Outcome measures relevant to Maori
5. Autaki - prevention/promotion	Disease prevention and health promotion are necessary for long-term gains Treatment services should not be compromised
6. Tikanga Maori and kaupapa Maori	Traditional healing Services based on Maori health and well being philosophies
7. Integration - intra- and inter-sectoral	Integration within the health sector and between health and other sectors
8. Resourcing Maori health and independence gains	Resources need to reflect the greater need and should match the government commitment to Maori health
9. Awatea - Maori development	Maori health should be linked with Maori development as described in <i>Ka Awatea</i> Maori development approach to health development

Source: Cunningham and Durie, 'Te renenga hauora' in Davis, P and Dew, K (eds) *Health and Society in Aotearoa New Zealand* 1999, p. 251.

According to Durie, the Rangatira framework provides a summary of current objectives for Maori health (Durie 1998b, p.211). Other frameworks developed by

the Ministry of Health (1997c) promote managed care options for Maori, or provide guidelines for service improvement. Managed care options are seen as having the potential to “fit . . . with a holistic, whanau-centred approach to health care” (Ministry of Health 1997c, p.107). The Ministry of Health has identified features of holistic, whanau-centred approaches to health care which it believes would be appropriate to promoting health interests, positive outcomes, and interactive holistic health services for Maori. These features have been identified through examining existing managed care models. Those examined include the MAPO (Maori Alternative Provider Organisation) structure developed between North Health and the three major iwi in this region - Tai Tokerau, Ngati Whatua, and Tainui (Ministry of Health 1997c, pp.107-112). The Ministry also examined services offered to Maori by Te Whanau O Waiperaira in the West Auckland area, and Te Oranganui in the Whangarei and Rangatikei districts.

After examining these examples of managed care options, the Ministry of Health identified that an “ideal” health service, or managed care option for Maori, would need to be: owned by the community it services; contributing to the training and development of that community; and evaluated by that community, using the holistic model of health, *Te Tapa Wha*, as the basis for promoting well-being. It would also need to: reduce the barriers for Maori in assessing effective health care services; be culturally, medically and physically safe; and be adequately resourced and effective (Ministry of Health 1997c, p.112). The MOH suggests that managed care programmes provide Maori with more flexible options for health care by devolving control and development of appropriate health services to Maori, who can then decide on appropriate directions for those services.

The Ministry claims that managed care options offer Maori the opportunity to exercise rangatiratanga. By becoming purchasers themselves, Maori can “control the funding mechanisms that determine all other aspects of health services” (Ministry of Health 1997c, pp.87-89). Reid (1999), however, questions the validity of managed care projects as an exercise in rangatiratanga. Reid argues that purchasers need to recognise and remunerate such initiatives so that Maori have real choice in, and realistic options for, health care. Purchasers need to acknowledge “the burden of

illness Maori . . . face, and have a commitment to equity and social justice” (Reid 1999, p.93).

Additional guidelines developed by the Ministry of Health for improving service provision need to be applicable to both mainstream and Maori health providers. He Taura Tieke (1995) was developed by the MOH as a framework for describing and assessing health service effectiveness. The focus of the framework, as shown in Table 3, is the development of appropriate measures of effectiveness with an emphasis on clinical competence, structural and systemic responsiveness, and consumer satisfaction (Durie 1998b, p.202). The short-term objective of the framework is to increase access to, and use of, health services so that Maori health gain occurs (Ministry of Health 1995a, p.2).

Table 3: *He Taura Tieke*: three-part framework for describing health service effectiveness

<u>Area of competence</u>	<u>Measure of effectiveness</u>
1. Technical and clinical competence	competence monitoring health framework
2. Structural and systemic responsiveness	Maori development Maori workforce development preferred providers
3. Consumer satisfaction	access information informed choice trust and respect participation seamlessness

Source: Cunningham and Durie, ‘Te renenga hauora’ in Davis, P and Dew, K (eds) Health and Society in Aotearoa New Zealand 1999, p.248

In order to achieve this objective, providers are asked to ensure that the health care Maori receive is comprehensive, integrated, and continuous (Ministry of Health

1995a, p.9). The Ministry recommends that providers ask themselves: what has been done to improve outcomes for Maori; how population health strategies can be used to promote health gain; and whether these strategies are relevant to Maori lifestyles and routines. In particular, the Ministry recommends that providers identify how they (Ministry of Health 1995a, pp.8-13):

- address and act on Maori social, cultural, and political factors to benefit Maori consumers
- assist Iwi, or Maori groups and organisations, to exercise authority over their own health affairs
- respect differences amongst Maori, as individuals and within groups
- allow Maori traditional healing processes to complement mainstream services

In a submission to the Maori Health Commission, a health worker from Te Tai Tokerau commented that health outcomes established for Maori by mainstream agencies were inappropriate. It was argued that health outcomes for Maori are measured in terms of non-Maori health that do not reflect the different health issues and barriers faced by many Maori. According to this submission, Maori have outcomes and outputs that “don’t fit the models that have been imposed upon us. We are struggling to survive because we can’t produce the ticks in the box. The means of evaluation in the Pakeha system are not appropriate for us” (Maori Health Commission 1998, p.21).

This argument is supported by evidence from the 1996/97 Health Survey which identified a number of areas where there are significant differences between Maori and non-Maori. A percentage of the data had gender and ethnic analysis applied to it which identified risk areas and behaviours for men and women, and for Maori and non-Maori. The researchers deliberately manipulated the data in order to obtain more reliable estimates for Maori and Pacific people, as health statistics for these groups are generally underreported and erroneous data sets subsequently result (Ministry of Health 1999d, p.8). Reid (1997), cited in Cunningham and Durie (1999), suggests that underreporting may be as high as 80 percent in some data sets for Maori (Cunningham and Durie 1999, p.252).

The aims of the 1996/97 Health Survey included (Ministry of Health 1999d, p.7):

- measuring the health status of New Zealanders, including their self-reported physical and mental health status, and prevalence of selected conditions
- measuring the utilisation of health services and prescriptions
- measuring individual's experience and knowledge of health services, including their satisfaction with health services and barriers to accessing health services
- providing information on selected health-risk behaviours
- providing this information at both a national and regional level and for population groups, especially Maori and Pacific people
- comparing results by key demographic and socio-economic variables

A key finding from the 1996/97 Health Survey was that the relationship between health development and socio-economic status is not always clear-cut. According to the Ministry of Health, this means that the “frequently documented linear association between improving health [development] and socio-economic status did not occur systematically in both ethnic groups, Maori and Pacific Islanders, or in both sexes, for all variables” (Ministry of Health 1999d, p.165). The Ministry explained the variances by examining other socio-cultural factors, and the impact socio-economic variables, such as income and employment, have for different cultures and sexes. The survey also examined the influence of intergenerational health outcomes and the cumulative effect of socio-economic indices on health status, across an individual's lifetime. The survey identified three variables as the main determinants of socio-economic status: the impact of family income, education, and deprivation (Ministry of Health 1999d, pp.12, 165, 206). Other theorists and studies have identified similar variables as significant barriers to health care for marginalised groups. The reader is referred to Mareroa (1999), Rahu (1999), Smith et al. (1997), and Syme (1996).

Disparities between Maori and non-Maori in terms of health outcomes

In the four decades following World War II, Maori life expectancy increased consistently. These increases have been seen as indicators of health status improvement relative to increases among non-Maori. Statistics New Zealand (1996),

cited in Reid (1999, p.92), state that Maori life expectancy at birth however, which had been improving relative to non-Maori throughout the twentieth century, has become static since 1990, while non-Maori life expectancy is still improving. Te Puni Kokiri (1996) also noted that the gap between Maori and non-Maori in terms of life expectancy had increased. In its post-election brief to the incoming Government (1996), TPK noted that prior to 1987, Maori had experienced a greater increase in life expectancy than non-Maori. Between 1950-52 and 1985-87, the gap between Maori and non-Maori life expectancy had declined from 15.4 years to 4.6 years respectively (Te Puni Kokiri 1996, p.112). From 1990-92, however, data showed that the gap had widened to 5.8 years. Te Puni Kokiri attributed this widening gap to a slowing of previous gains in Maori health status while non-Maori health gain has continued (Te Puni Kokiri 1996, p.112).

These figures are supported by data from the Ministry of Health (1999a). Table 4 shows life expectancy for Maori and non-Maori, at selected ages from 1995 to 1997. The data has been disaggregated by gender, age, and ethnicity. Table 4 shows that at birth, Maori men and non-Maori men have a life expectancy of 67.23 years and 75.31 years respectively. Moreover, Maori women have a life expectancy of 71.64 years while non-Maori women have a life expectancy of 80.60 years. This equates to a difference, or Maori gap, at birth of 8.08 years for Maori men, and 8.96 years for Maori women, respectively. Table 4 indicates that while this gap has closed between birth and ages 15 and 45, Maori still have a significantly shorter life expectancy than non-Maori.

Table 4: Life expectancy at selected ages, by gender and ethnicity, 1995-97

Age	Non-Maori			Maori			Maori gap	
	Male	Female	Diff	Male	Female	Diff	Male	Female
0	75.31	80.60	5.29	67.23	71.64	4.41	8.08	8.96
1	74.73	79.98	5.25	66.99	71.38	4.39	7.74	8.51
15	61.00	66.20	5.20	53.37	57.69	4.32	7.63	8.51
45	32.81	37.13	4.32	26.16	29.36	3.20	6.65	7.77
65	15.79	19.33	3.54	12.23	14.54	2.31	3.56	4.79
85	5.06	6.16	1.10	3.94	5.19	1.25	1.12	0.97

Source: Ministry of Health, *Our Health, Our Future- Hauora Pakari, Koiora Roa: The Health of New Zealanders 1999* 1999c, p.112

Te Puni Kokiri (1998) also provides further evidence of an increase in disproportionate outcomes between Maori and non-Maori. In a 1998 report on progress made towards closing social and economic gaps between Maori and non-Maori, a key focus of policy, Te Puni Kokiri argued that: “the historical disadvantage faced by Maori in the areas of education, employment, economics and health status has been well documented . . . It is disturbing to find that despite improvements for Maori in some areas, gaps have either remained the same or widened” (Te Puni Kokiri 1998a, p.1). The gap is widening, not only in terms of life expectancy, but also in terms of socio-economic status (see chapter four), relative income levels, mortality rates, and the onset of chronic illness or disease.

For example, in adults aged 25 years and over, Maori health trends as reported against key health indicators show that (Te Puni Kokiri 1999c, p.75):

- the incidence of some cancers, for example, lung, cervical, and stomach, remains higher for Maori
- Maori rates of diabetes have always been high and are increasing
- hospitalisation rates for Maori due to stroke has widened by comparison with non-Maori
- hospitalisation rates for pneumonia and influenza are more pronounced for Maori than non-Maori, and the gap has widened considerably over the last ten years
- psychiatric hospital admissions for Maori have increased more than non-Maori

Another important factor in health development assessment is Independent Life Expectancy (ILE), or life expectancy free from disability or dependency. In Our Health, Our Future 1999 (1999c), the Ministry of Health argues that ILE is a key indicator of health status and health expectation. The Ministry argues that the ratio of Maori to non-Maori ILE at birth, demonstrated by data for this time period (1996-97), provides a “single, whole of population indicator of the inequality in health status between the two groups” (Ministry of Health 1999c, p.244). In 1996, this ratio equalled 85.2 percent for women and 87.3 percent for men. Translated into outright terms of health expectation for Maori and non-Maori, as measured by ILE at birth,

this shows that Maori health was 14 percent less than that of non-Maori in the same year (Ministry of Health 1999c, p. 244).

Analysis of the available data indicates that Maori experience less quality of life at all ages, both in terms of specific health outcomes, and in terms of years lived free from disability. Life lived free from disability is referred to as health expectancy. Overall, Maori have a significantly shorter life expectancy (LE) and a shorter independent life expectancy (ILE) than non-Maori at every age (Ministry of Health 1999c, p.244). Evidence of this disparity is demonstrated in Table 5. Table 5 looks at gender and ethnic differentials in LE and ILE at selected ages from 1996 to 1997. Table 5 demonstrates that while the differential in life expectancy at birth for Maori and non-Maori men is 8.1 years, the differential in independent life expectancy is 8.3 years. For Maori and non-Maori women, the figures are 8.3 years and 10.2 years respectively. Table 5 indicates that both Maori men and women live shorter, more dependent lives than their non-Maori counterparts (Ministry of Health 1999c, p.244).

Table 5: Gender and ethnic differentials in life expectancy and independent life expectancy at selected ages, 1996-97

		Gender gap (years)		Ethnic gap (years)	
		Non-Maori	Maori	Male	Female
At birth	Life expectancy	5.3	4.4	8.1	9.0
	ILE	3.3	1.4	8.3	10.2
At age 15	Life expectancy	5.2	4.3	7.6	8.5
	ILE	2.8	0.6	7.5	9.7
At age 45	Life expectancy	4.3	3.2	6.6	7.7
	ILE	2.6	0.0	5.4	8.0
At age 65	Life expectancy	3.5	2.3	3.6	4.8
	ILE	2.0	0.1	2.5	4.4

Source: Ministry of Health, *Our Health, Our Future - Hauora Pakari, Koiora: The Health of New Zealanders, 1999* 1999c, p.244

Source of base data: Statistics New Zealand

Note: gender gap = female to male; ethnic gap = non-Maori to Maori

Summary

The purpose of this chapter has been to define what is meant by Maori health development, and to analyse Government responsibility to Maori under the partnership established by the Treaty of Waitangi. If, as Durie proposes, Maori health development involves Maori defining their own priorities for health, and then “weaving a course to realise their collective aspirations” (Durie 1994, p.1), then it would seem that devolution to Maori through schemes such as managed care options, and the Maori Provider Development Scheme, would offer Maori an opportunity to do this. The growth of disproportionate outcomes between Maori and non-Maori over the course of the last decade would appear to indicate otherwise. Government has an obligation under the Treaty to foster positive outcomes for Maori, and a commitment has been to this end by governmental agencies. This commitment, however, has yet to be sanctioned in social legislation. For example, section 8 (e) of the Health and Disability Services Act (1993) refers to the special needs of Maori and other groups, but does not expressly mention the Treaty.

Concern also exists amongst Maori that the Ottawa Charter (1987) will supercede the place of the Treaty in health development practice in New Zealand. To this end, Messiter (1995) has developed a Treaty perspective that employs the objectives of the Ottawa Charter without detracting from the importance of the Treaty for Maori. An important theme in the Ottawa Charter is that of developing, or enhancing, healthy public policy. From Messiter’s perspective, this offers Maori the opportunity to receive top priority from a Treaty of Waitangi perspective in terms of health development. A key emphasis in the Charter is that of health promotion. Health promotion is seen as an effective first point of contact for groups suffering disproportionate health outcomes. Health promotion programmes offer individuals and communities the opportunity to increase control over, and improve, their health (Ministry of Health 1997b, p.6).

The purpose of policy revision is to identify why policy is not as effective as is desired, and to identify alternative options which may improve outcomes. Applying this to Maori health development, it is suggested that policy frameworks employ these Treaty principles in seeking to improve health outcomes for Maori. Complementary

roles for the Treaty partners are also seen as essential in improving outcomes for Maori. The Ministry of Health argues that the health sector cannot be “held accountable for the socio-economic status of Maori, but it can be asked to consider how it responds to health needs created by low income and social disadvantage” (Ministry of Health 1998a, p.7). It is suggested, here, that health needs, created by low income and social disadvantage, are a result of the colonial history of Aotearoa New Zealand in terms of the Treaty of Waitangi.

Ramsden argues that unless this country “recognises and works with its neo-colonial reality, race relations and the future quality of life for Maori will continue to be seriously and negatively affected” (Ramsden 1994b, p.109). The purpose of employing Treaty frameworks in policy development is to try and address these factors, and to identify the Treaty’s role in the development of health and social policy to benefit Maori people. Active health protection policies should be motivated by concerns over inequitable health development for Maori. Inequitable health development for Maori, and Government response, in terms of socio-economic outcomes, is discussed in more depth in chapter four.

CHAPTER FOUR

Socio-economic Determinants of Health

Introduction

There has been for some time wide acceptance that the 'medical model' of health, in which ill-health is considered to be primarily the result of exposure to single agents, is at best only a partial explanation of the variation in individuals' and communities' health. This has led to a shift in emphasis from a medical to a social model in the search to explain disparity in health status

- Nuthall 1992, p.1

In a study on the impact of social and economic factors on health development, Beaglehole and Howden-Chapman, cited in (Nuthall 1992, p.i), argue that the major determinants of health status in New Zealand are economic and social in origin, but that little attention has been paid to these issues in either the research or policy areas. They subsequently recommended, as a result of increasing inequities in health outcomes in New Zealand, that policies should "be designed to influence social and economic factors" which have an impact on health development. Income and social class are two socio-economic variables which the literature cites as having a significant impact on health development. Pomare and de Boer (1988), cited in Te Puni Kokiri (1991), note that barriers of money and class "not only affect people at the lowest end of the socio-economic scale but they also affect the person's ability to use the health services that are available" (Te Puni Kokiri 1991 p.40).

The purpose of this chapter is to examine the impact of the relationship between socio-economic status and health outcomes on Maori health development, and the approach taken by Government to address this impact. The Ministry of Health believes that "while many elements of the social environment are outside the sphere of influence of individual government agencies, collectively [governmental] agencies can contribute to the reduction of barriers which produce disparities in health status" (Ministry of Health 1997c, p.69). The Ministry also believes that policies designed to

benefit people with poor health outcomes need to be more visible, and that people need to become aware of them (Ministry of Health 1999d, p.6). Consequently, an essential objective of policy is to identify the causes of poor health. This objective is reflected in documents such as Towards 2010, and the development of Strategic Result Areas (SRAs), and Key Result Areas (KRAs). SRAs and KRAs represent collective Government and individual agencies' priorities for reducing disparities between Maori and non-Maori, respectively.

Maori health development during the 1990s

The impact of socio-economic determinants on health development show in higher rates of hospitalisation, morbidity, and mortality for Maori than for non-Maori, where morbidity is defined as health-related quality of life (Ministry of Health 1999c, p.56). In its post-election briefing to the incoming Government in 1996, Te Puni Kokiri identified that Maori health status, based on conventional measures, namely rates of hospitalisation, morbidity, and mortality, is poorer than that of non-Maori (Te Puni Kokiri 1996, p.111). Although the major causes of hospitalisation for Maori are the same as for non-Maori, Maori rates of hospitalisation are considerably higher than those of non-Maori. Higher rates of hospitalisation, morbidity, and mortality can also prevent Maori from effectively exercising rangatiratanga. Te Puni Kokiri argues that the most striking disparities occur with asthma, diabetes, pneumonia and influenza. In its brief to Government (1996, p.114), Te Puni Kokiri presented the following statistics:

- Maori rates of hospitalisation for asthma are almost four times higher than for non-Maori
- Maori rates of hospitalisation for diabetes are almost five times higher than for non-Maori
- Maori rates of hospitalisation for pneumonia and influenza are three times higher than for non-Maori

Te Puni Kokiri also claimed that, on some measures, Maori health status has declined during the 1980s and 1990s. According to Te Puni Kokiri (1996, p.111), this decline can be partly attributed to lower Maori socio-economic status. Other factors identified as contributing to lower Maori health status are lifestyle factors and cultural

barriers. Te Puni Kokiri argued that these factors might prevent Maori from adequately accessing health services. Certain lifestyle factors, such as heavy tobacco use, inappropriate diet, lack of exercise, and alcohol and drug use, can significantly affect health development. Pomare et al. (1995, p.151) argue that while tobacco use is the single greatest preventable cause of premature death amongst Maori, diet also contributes significantly to Maori rates of diabetes, heart disease, and cancer.

For Maori and non-Maori alike, the impact of socio-economic variables on health development determines whether *waiora*, or health, is attained. Key variables include income, education, employment, housing and welfare. Ethnicity, culture, social class, area of residence, and family structure are also seen as important determinants of health development. Of these variables, income is generally held to be one of the most important determinants of health status, closely followed by education. There is a well-documented relationship between income and health status in the literature. For an overview of the relationship between income and health status, the reader is referred to Calman (1997), Drife (1993), and Judge et al. (1998).

According to Blank, there is substantial evidence to support McKeown's (1976) argument that health services are not as important in determining health status as social, economic, lifestyle, and environmental factors (Blank 1994, p.151). Blank based this argument on an assessment of Nuthall's (1992) research which examined the impact of socio-economic factors on health development. Blank argues that lifestyle factors such as unemployment, drug and alcohol abuse, crime, and social deprivation are also important in health development. Consequently, these factors should be taken into account in health policy development (Blank 1994, p.151).

The health sector, macro- social and economic policies, and collaborative initiatives between various governmental agencies also play important roles in the determination of health status. The National Advisory Committee on Health and Disability (NAC), which looked at the relationship between the cultural, social and economic determinants of health, claimed that it is as important to identify the main factors which protect and promote good health, as it is to develop good policy (National Advisory Committee 1998, p.8). The Committee also claimed that appropriate health

intervention strategies need to be developed at policy and regional levels within the health sector. This includes assessing the marginal cost effectiveness, or cost utility, of different policy options (Ministry of Health 1999c, p.58). The following evidence was given by the NAC to support these arguments (National Advisory Committee on Health and Disability 1998, p.14):

- health sector interventions may reduce the health impact of socio-economic disadvantage, but may only have a limited effect on socio-economic inequities in health
- analysing the potential impact of macro-social and economic policies on the health of the population should be an integral part of the policy process
- intersectoral initiatives are able to improve health where the efforts of single agencies may have limited effect

The impact of socio-economic determinants on health status

A number of international studies have identified the interdependent relationship between socio-economic status and health development. Studies have found that this relationship is accumulative, has intergenerational effects, and that people in lower socio-economic classes experience higher rates of illness for all forms of disease, virtually without exception (Howden-Chapman 1999, pp.73-78). Smith et al. (1997), cited in Howden-Chapman (1999, p.77), found that socio-economic factors have a lifetime impact on health, and increase the risk of premature death from cardiovascular disease and cancer, although the “relative importance of influences at different stages [vary] for the causes of death”. Studies have also found that family income independently predicts mortality, and that inequities in health status develop from both behavioural and structural factors (Howden-Chapman 1999, pp.73-77).

Rapid social and economic change is also associated with psychosocial factors and poor health status. In terms of health development, Stronks et al. (1996), cited in Howden-Chapman (1999, pp.77-78), found that the total contribution of structural factors, including both implicit and explicit policy influences, outweighs the contribution of behavioural factors to health development. Implicit policy objectives are the unintended, or unforeseen, results of policy which can have either a negative or a positive effect. Explicit policy objectives are the goals of each particular policy,

whether they are realised or not. Nuthall (1992) suggests, however, that the impact of these influences on health development can be deflected or increased if “moderating variables” also exist. Nuthall defines moderating variables as “those things which make people less [or more] likely to suffer the ill-health effects of social and economic disadvantage” (Nuthall 1992, p.25). Not all those who are unemployed, on low incomes, or in lower social classes experience poor health.

The example used by Nuthall to demonstrate this point is the relationship between unemployment and health status. In terms of this relationship, moderating variables can include the absence of other life stresses, a supportive social environment, and short rather than long periods of unemployment (Nuthall 1992, pp.25-26). Some moderating variables, however, may make people more likely to suffer from poor health outcomes. For example, the presence of occupational factors or pollution may exacerbate the impact of socio-economic disadvantage on health development. For a detailed analysis of studies conducted into the relationship between socio-economic status and health development, the reader is referred to Smith et al. (1997), Fiscella and Franks (1997), Stronks et al. (1996), Levin et al. (1994), Bollock and Marmot (1996), and Syme (1996).

Other international studies which examined the impact of socio-economic status on the health development of marginalised, or minority, groups have likewise found that the effect of structural factors on health development can be as equally important as the impact of socio-economic variables. A 1994 Organisation for Economic Co-operation and Development (OECD) report, cited in Howden-Chapman (1999, p.78), which looked at health policy in comparable OECD countries, suggested that lower, or decreasing, health status is primarily the result of certain groups being marginalised from health care systems. In 1996, Te Puni Kokiri advised Government that one of the biggest challenges facing Maori as a result of public sector restructuring is the “increasingly large number of Maori who are becoming alienated from mainstream social and economic systems” (Te Puni Kokiri 1996, p.5). This argument had previously been employed by Beaglehole and Howden-Chapman (1992), cited in Nuthall (1992, p.i), who argued that the emphasis placed on market forces in the restructuring of the health sector downplayed the importance of wider contextual factors in health development. According to Pomare et al. (1995, p.150), changing

sector policies and their impact on employment and income “may have prevented the benefits of Maori development from reaching Maori individuals and whanau”.

In a study of social dimensions of health and disease in New Zealand, Spicer et al. (1994), examined the influence of implicit and explicit policy objectives on health development. They argued that implicit policy influences are those which, although not specifically directed towards the outcome intended, still have a positive or negative, direct or indirect effect. For example, in the relationship between health status and income maintenance policy, income maintenance policy is both implicit and significant because of the interdependent relationship between health development and household, or individual, income (Spicer et al. 1994, p.40). Spicer et al. suggested that socio-cultural values are problematic in this regard as although socio-cultural values are part of a health context, they are usually not formalised in the same way as policy (Spicer et al. 1994, p.40). Te Puni Kokiri argues that the seriousness of this issue is exacerbated by “a lack of concerted political will [to] provide direction and resources” (Te Puni Kokiri 1996, p.10), and policies and programmes which are accessible and appropriate for all Maori.

The effects of deprivation on health development

The National Advisory Committee (NAC) argues that the relationship between socio-economic conditions, specifically deprivation and health, “operates in both directions, but primarily it is deprivation that leads to poor health rather than vice versa” (National Advisory Committee 1998, p.12). Other important links between socio-economic status and health development include levels of deprivation, either relative or absolute, and gender and cultural roles. Deprivation affects health status through its impact on social networks. Deprivation can also directly affect individual physical and mental health, and can be compounded by a lack of social or family networks to provide support. Relative deprivation, or poverty, is defined by the National Advisory Committee as “. . . [identifying] a gap between what is and what might be, showing what potential exists for improvement. It is measured by comparing individuals or groups, and relating them to some norm, defined locally, nationally, or internationally” (National Advisory Committee 1998, p.107). Absolute poverty is

defined as “some absolute standard of minimum requirement for survival and functioning in a community” (National Advisory Committee 1998, p.102).

By comparison, Townsend defines deprivation, cited in Crampton and Davis (1998, p.82), as a state of “observable and demonstrable disadvantage relative to the local community, or the wider society or nation, to which an individual, family, or group belongs”. Crampton and Davis (1998, p.82) suggest that the need to measure deprivation is becoming increasingly important so that resources can be distributed to those with the highest need. Crampton and Davis based this recommendation on an examination of *NZDep96*, an area-based index of deprivation, and *NZSEI*, the New Zealand socio-economic index. *NZDep96* measured area deprivation based on variables from the 1996 Census, while the *NZSEI* examines the impact of socio-economic factors at an individual level.

Both *NZDep96* and the *NZSEI* examined implications for policy which develop from the relationship between deprivation, socio-economic status, and health development. Crampton and Davis claim that there are three reasons why measures of deprivation, and socio-economic status, have increasing relevance for health policy and service provision. These are (Crampton and Davis 1998, pp.81-84):

- measures are required if primary care, and public health initiatives, are to be effectively targeted to areas of highest need, in a similar manner to resource allocation
- there is a research imperative to investigate and monitor trends, for example, avoidable mortality, in different socio-economic groups to inform policy
- those involved with planning, purchasing, and researching of health services need to understand and use such measures, so that deprivation and socio-economic status become more visible in decision-making

The links between deprivation, or poverty, and ill health are demonstrated by higher rates of morbidity and mortality amongst Maori. The National Advisory Committee on Health and Disability (NAC) argues that levels of deprivation amongst Maori have increased markedly during the 1990s, largely in response to changes in housing

policy, and economic policy. The effects of changes to housing policy were indicated by an increase in serious housing need during this time. This increase in need has been documented by Waldegrave and Sawrey (1994), and the NAC (1998). The NAC argues that with few exceptions, the financially worse off experience decreased levels of health, higher rates of illness, and premature death (National Advisory Committee 1998, p.8).

Evidence also suggests that children who enter single-parent families at birth are more likely to suffer higher rates of deprivation throughout life. Ferguson et al (1981a), cited in Nuthall (1992, p.32), argue that children entering single-parent families at birth are more likely to be exposed to a “systematic pattern of disadvantage”. This pattern of disadvantage includes: poor preventative care, greater risks of morbidity, decreased levels of access to pre-school education, impaired mother/child interaction, depressed living standards, and greater family instability. The links established by Ferguson et al (1981a). between single-parent households, health outcomes, and socio-economic status also include significant housing issues. Housing is perceived to have three direct impacts on health development: the cost, structural condition of the house, and location of housing all directly affect health outcomes. Lack of permanent housing, or substandard housing, increases the risk of ill health, especially for children. This particularly affects Maori or Pacific Island families who may experience limited housing options due to lower, or restricted income (Nuthall 1992, p.vi).

Maori health outcomes and socio-economic status

Statistics released by Te Puni Kokiri in 1993 and in 1998 indicated that the introduction of market rentals for State housing, in conjunction with public sector restructuring and higher unemployment rates, had impacted heavily on groups which experience poor health outcomes and low socio-economic status. According to Te Puni Kokiri (1999c, p.1), the late-1980s were characterised by “soaring Maori unemployment, falling labour force participation, and growing long-term unemployment”, leading to low socio-economic status and impaired health outcomes for Maori. Under the economic conditions of the early 1990s, these trends started to reverse, although unemployment rates in areas such as Northland and the West Coast

remained high. Between 1997 and 1999, however, Te Puni Kokiri (1999c) argues that there has been little change in the Maori position. Maori unemployment has started to rise for the first time since 1991, and Maori are three times more likely to be unemployed than non-Maori. Te Puni Kokiri argues that the disparity between Maori and non-Maori is now wider than it was a decade ago (Te Puni Kokiri 1999c, p.1).

Pomare et al. (1995) argue that Maori have become relatively worse off compared to non-Maori in terms of the impact of socio-economic status on health development since public restructuring began in the mid-1980s. This argument is based on income distribution evidence from Maori households during the 1990s, and educational qualifications indicated in past Census (Pomare et al. 1995, p.145). The following evidence was given by the National Advisory Committee on Health and Disability (1998), Te Puni Kokiri (1998b), and Statistics New Zealand (1998) to support Pomare et al's argument:

- in the eleven year period from March 1982 to March 1993, gross household income fell by 15 percent on average
- over the same period, disposable income fell by 10 percent
- after adjusting for household size, households with children, particularly sole-parent, Maori and Pacific Island households, have been most severely affected by these changes
- in 1987, Maori households received 22 percent less income than non-Maori households; this had increased to 26 percent less income by 1997
- in 1986, 53 percent of Maori left school with no formal qualifications. This had decreased to 34 percent by 1993, but increased again to 39 percent by 1996

(National Advisory Committee 1998, p.23; Te Puni Kokiri 1998b, p.4;
Statistics New Zealand 1998, p.48)

Statistics New Zealand claims that an understanding of socio-economic disparities between Maori and non-Maori is crucial to “the formulation of policies which seek to address the disadvantages faced by Maori” (Statistics New Zealand 1998, p.9). Te Puni Kokiri has addressed a number of these issues for Maori in documents such as He Kakano: a handbook on Maori health data (1993), and Progress Towards Closing

Social and Economic Gaps Between Maori and non-Maori: a report to the Minister of Maori Affairs (1998a). Table 6 demonstrates average annual income for Maori households and non-Maori households. Table 6 shows that the gap between Maori and non-Maori households in terms of average annual income increased between 1987 and 1997. In 1987, Maori received an annual average income of \$26 200, compared with \$31 800 for non-Maori. This represented a gap of \$5 600, or 22 percent. By 1997, Maori received \$10 000 less per annum (26 percent) than non-Maori, an increase of 4 percent (Te Puni Kokiri 1998b, p.4).

Table 6: Average annual income for Maori households versus non-Maori households

Year	Maori households	non-Maori households	Gap
1987	\$26 200	\$31 800	\$5 600 (22%)
1997 (26%)	\$37 200	\$47 200	\$10 000
Increase	42%	48%	6%

Source: Te Puni Kokiri Whakapakari: hunga mahi - Trends in Maori employment, income, and expenditure 1998b, p.4

** Data not standardised for age

An analysis of a sample of people by Statistics New Zealand (1998) from the 1996 Census who were full-time employed, and aged 18 years or over, examined the chances of Maori and non-Maori falling into particular socio-economic categories. For example, did they receive a benefit, or were they in a high or low educational, occupational, or income group? According to Statistics New Zealand, this sample indicated that Maori who were in full-time employment were almost two and a half times more likely than their non-Maori counterparts to be in the lowest income range (\$10 000 or less), than in the highest income range (\$50 001 or more) (Statistics New Zealand 1998, p.78). This income difference was reflected in median incomes. In 1996, full-time employed Maori had a median income of \$24 100, compared with \$28 800 for non-Maori. Maori showed lower median incomes than non-Maori for all occupations (Statistics New Zealand 1998, pp.78-79). Statistics also showed that of those who were full-time employed, Maori were twice as likely than non-Maori to have received a benefit in the year prior to the 1996 Census (Statistics New Zealand 1998, p.84).

The relative fall in income position of Maori between 1986 and 1991 reflected the increase in Maori unemployment. Statistics New Zealand argues that income is an important measure of social and economic well being because it provides an indication of the economic status, and living standards of individuals and households (Statistics New Zealand 1998 pp.73-74). Employment is also a key determinant of health status. In addition to the provision of income, regular employment improves self-esteem, which, in turn, enhances social well being (National Advisory Committee 1998, p.28). Employment affects income, health, housing, education, and family life (Statistics New Zealand 1998, p.59). The National Advisory Committee on Health and Disability argues that employment also provides social contact and a:

“way of participating in community life. [It also] enhances opportunities for regular activity. [All of these factors] help to enhance individual health and well-being” (National Advisory Committee 1998, p.28).

Statistics New Zealand argues that the economic changes in New Zealand since the early 1980s have had a significant effect on Maori employment with major job losses in sectors in which Maori were highly represented. In 1986, the labour force participation rate for Maori was 68.8 percent. By 1991, this had dropped to 56.4 percent (Statistics New Zealand 1998, p.60). Maori men were more likely to experience this decline than Maori women. From 1986 to 1991, the labour force participation rate of Maori men fell 15.9 percentage points, almost twice the decline experienced by Maori women (Statistics New Zealand 1998, p.60). However, from 1991 to 1996, labour force participation rates for Maori increased. At the 1996 Census, 65.4 percent of Maori aged 15 and over were in the labour force (Statistics New Zealand 1998, p.60).

Unemployment rates for Maori also rose between 1986 and 1991, but fell again between 1991 and 1996. Despite this trend, Maori were almost three times more likely than non-Maori to be unemployed in 1996 (Statistics New Zealand 1998, p.10). According to Statistics New Zealand, Maori made up 27.7 percent of all unemployed people in 1996 but only 12.3 percent of the total working-age population (Statistics New Zealand 1998, p.68). Employment statistics also show that Maori, on average, receive lower incomes than non-Maori. Statistics New Zealand (1998) argues that median incomes for Maori fell as a proportion of non-Maori incomes between 1986

and 1991, but increased again by 1996. Maori income levels did not, however, reach the level of a decade earlier despite increases between 1991 and 1996 (Statistics New Zealand 1998, p.10).

Educational achievement also has an important impact on employment opportunities, and thus, on health status. Participation and achievement by Maori in educational programmes have increased since the late 1980s. Maori are now more likely to stay at school longer, and to leave with qualifications. Considerable growth has also been recorded in the number of Maori enrolled in tertiary education, which has resulted in a higher proportion of Maori obtaining post-school qualifications (Statistics New Zealand 1998, pp.9-10). Disparities still remain, however, in terms of educational achievement between Maori and non-Maori. Statistics New Zealand (1998) argues that these changes have occurred within a “context of increasing educational participation and attainment amongst the population as a whole, with the result that further improvements for Maori are needed if disparities in educational outcomes are to be reduced” (Statistics New Zealand 1998, p.10).

Statistics from the 1996 Census highlighted that:

- 45 percent of Maori aged 15 years and over held formal educational qualifications, the same proportion as the 1991 Census
- Maori aged between 15 and 19 years were most likely to have gained a highest qualification at secondary school level (45 percent), while those aged between 30 and 49 years were more likely to have gained post-school qualifications
- of those in the workforce, Maori without qualifications were almost twice as likely to be unemployed (23 percent), as those with qualifications, (12 percent)
- 17 percent of Maori were single-parent families with children, as compared with 19 percent in the 1991 Census
- 24 percent of Maori households had an average annual of \$ 20 000 or less
- the median income for all Maori was \$34 740
- the median income for one-parent Maori families with dependent children was \$13 147 and \$12 839 annually, for men and women, respectively

- 95 628 Maori were receiving either an Unemployment Benefit or a Domestic Purposes Benefit in 1996; the figures were 58 908 (9 percent), and 36 720 (5 percent) respectively
- 88 632 (11 percent) Maori received Income Support as their only form of income; of these 34 566 were men (5 percent), and 54 066 were women (8 percent)
- 54 percent of Maori were employed, while 11 percent were unemployed (Statistics New Zealand 1997, pp.17, 90-92, 107-108, 130-133)

Statistics New Zealand (1996), cited in Reid (1999, p.92), argues that in terms of traditional health status indicators, specifically life expectancy, Maori health status has remained static, or even regressed since 1990. This argument is supported by the National Advisory Committee (1998). In a study on the social, cultural and economic determinants of health, the Committee found that despite an overall improvement in population health status, “socio-economic inequalities in health [for Maori] have not decreased over the past two decades, and may even be increasing” (National Advisory Committee 1998, p.44). Key findings and suggestions from the study are:

- that social, cultural, and economic factors are the main determinants of health
- there are persisting health inequalities as a result of socio-economic factors in New Zealand, and some evidence that these may be worsening
- current trends in many socio-economic factors in New Zealand are likely to widen health inequalities further
- there are good reasons for intervening to reduce socio-economic inequalities in health
- there are evidence-based interventions for reducing these inequalities (National Advisory Committee 1998, p.3)

Evidence from other studies is given by the National Advisory Committee to support these findings, and further indicate the important relationship between education and health. In a study conducted by the Ministry of Education (1997) on adult literacy, the Ministry found that over 60 percent of Maori, Pacific Island people, and members of other ethnic minority groups are functioning below the level of literacy required to

effectively manage in everyday life (cited in National Advisory Committee 1998, p.9). This result is supported by evidence from the 1996 Census. The Census found that 39 percent of Maori left school in 1996 with no formal qualifications, as compared to 27 percent of Pacific Island people, and 14 percent of other ethnic groups (National Advisory Committee 1998, p.9). A low level of education is generally associated with poor health status, and higher rates of morbidity, poverty and deprivation. The National Advisory Committee argues that socio-economic inequalities in health are reducible, and that seeking ways to reduce them is equitable because people themselves have “limited control over the socio-economic factors that are detrimental to their health” (National Advisory Committee 1998, p.13).

Efforts to combat the impact of socio-economic factors on Maori health development

In a report to the Minister of Maori Affairs in 1998, Te Puni Kokiri notes that one of Government’s strategic objectives for Maori development is to “make significant progress towards closing the economic and social gaps between Maori and non-Maori” (Te Puni Kokiri 1998a, p.6). The purpose of this report, Progress Towards Closing Social and Economic Gaps Between Maori and non-Maori, was to examine progress made towards this objective, through providing an umbrella view of progress across the education, employment, economic, and health sectors, and to provide a benchmark for future progress to be measured against. TPK also sought to examine the cumulative effect of public policy as a whole on the relative position of Maori in society (Te Puni Kokiri 1998a, pp.6-8). TPK argues that although there is “no denying that Maori experience poorer educational outcomes, higher unemployment, lower income levels, lower rates of home ownership, and poorer health than non-Maori”, until now it has been difficult to assess whether disparities have been improving or getting worse (Te Puni Kokiri 1998a, p.8).

This has been partly due to the poor quality of the data collected by mainstream agencies, changes to the collection of Maori data after 1995, and ad hoc reporting of data (Te Puni Kokiri 1998a, p.8). In a review of the Ministry of Health’s (MOH) service delivery to Maori in 1997, Te Puni Kokiri commented that the data available limited comparisons between Maori and non-Maori health. At this time, data was

collected by mainstream agencies, such as hospitals and General Practitioners, on specific types of mortality (causes of death), and morbidity (causes of illness or disease). Data was not being collected, however, on measures that could be associated with a concept of Maori health (Te Puni Kokiri 1997, p.11).

The Ministry of Health suggests that this discrepancy could be addressed through the introduction of appropriate data management and collection systems as outlined in its Health Information Strategy to the Year 2000 (1996). As part of this strategy, the Ministry publishes an annual report on progress towards health outcome targets for Maori. The first year that the Ministry monitored ethnic-specific hospitalisation and mortality trends for Maori since changes were made to the collection of ethnicity data was 1998. The Ministry argues that although these changes have “disrupted the historical time series for Maori . . . [they mean] that better ethnicity data [is] available than previously” (Ministry of Health 1998c, p.iii). Te Puni Kokiri (TPK) also sought to address these issues by pulling historical data together across the key sectors of education, employment, economics and health. TPK argues that these indicators were selected because time series data was available for them, and because they represented areas where considerable disparities exist (Te Puni Kokiri 1998a, p.8).

Consequently, TPK (1999c) identified that the advancement of Maori social and economic outcomes was a Key Result Area (KRA) for the Ministry in its post-election brief to the Government in 1999. TPK also identified that closing the gaps between Maori and non-Maori socio-economic outcomes is the collective responsibility of Government. TPK desires to meet this responsibility through improving policies and services affecting hapu, iwi, and Maori, so that there is progress towards parity (Te Puni Kokiri 1999c, p.77). The Ministry of Health (MOH) is also expected to work towards this objective. Both Ministries have established KRAs and Strategic Result Areas (SRAs) which directly relate to Maori health. SRAs and KRAs are derived from the Government’s vision and strategic goals outlined in Towards 2010, which is the Government’s stated policy direction heading into the twenty-first century.

SRAs indicate areas that governmental agencies will collectively target while KRAs indicate how specific agencies will individually contribute to SRAs (Te Puni Kokiri 1999c, pp.11, 21-22). The Ministry of Health’s SRAs that relate directly to Maori

health are SRA 7 and SRA 8. Through SRA 7, the Ministry of Health seeks to achieve “improvements in the health status of Maori by increased responsiveness to their needs, and the development of appropriate professional, administrative, and organisational expertise” (Te Puni Kokiri 1997, p.23). More specifically through SRA 8, the Ministry of Health seeks to develop policies and processes that lead towards closing the economic and social gaps between Maori and non-Maori (Te Puni Kokiri 1997, p.23).

A study by Pomare et al. (1995) argues that an urgent need exists to back up statistics on Maori health with courses of remedial action that specifically address these issues. Two key recommendations from this study are: one, policies need to be developed for Maori that recognise the socio-economic context that determines and shapes health outcomes; and two, ongoing effort needs to continue with specific issues which negatively affect Maori health (Pomare et al 1995, p.167). Pomare et al. also examined Maori rates of presentation to General Practitioners (GP), concentrating on expected rates of presentation by Maori women and children. It was found that Maori are less likely than other ethnic groups to present to a GP at all. If they do present, it is normally at a later stage of presentation, or “crisis point” (Pomare et al. 1995, p.162). These findings were reinforced by research conducted by Dr. Sue Crengle at Wai Health, Henderson, West Auckland. While practising at Wai Health during the early- to mid-1990s, Crengle, cited in McLoughlin (1996), identified that significant inequities in health outcomes still existed between Maori and non-Maori, despite Maori health being designated as a health gain priority area since 1984.

Crengle noted that a crucial point of difference lay in excess Maori mortality in situations where such mortality was largely avoidable, namely, cot death, and coronary heart disease (McLoughlin 1996, p.81). Wai Health deals with large sections of the West Auckland Maori community that generally do not access a doctor unless the situation is critical. This is known as “crisis health care”. In addition to Maori patients presenting later, Crengle noted that this section of the West Auckland Maori community constitutes a group “. . . whose lack of a relationship with a GP has resulted in poor management of their health” (McLoughlin 1996, p.81). Crengle also states:

“ . . . a lot of our people have multiple problems and have them at a younger

age than the rest of the population. It's everything from asthma to eczema, diabetes, high blood pressure, rheumatic fever, heart disease, glue ear . . . all the illnesses that come from being on low incomes . . . I can't think that we'll make a lot of change until we get more Maori health services and until we look seriously at the broader health determinants of poverty" (McLoughlin 1996, p.81).

Studies, such as Te Hoe Nuku Roa: Maori profiles research project (1999), a longitudinal study being conducted over a twenty year period on the impact of socio-economic status on health development for Maori, are an invaluable source of primary information. The Te Hoe Nuku Roa project has an aim of providing a "sound empirical base that will inform Maori, and other planners, and facilitate the development of policies and programmes appropriate to Maori advancement in cultural, social, and economic terms" (Te Hoe Nuku Roa Research Team 1999, p.9). The study has four express aims. First, the provision of a Maori policy framework so that analysis can occur as to whether advancements are occurring in personal and family circumstances. Second, examining the relationships of Maori families and individuals with structures in New Zealand society at local, regional, and national levels. Thirdly, providing a basis for the development of co-ordinated policies and programmes through the integrated nature of the study. Finally, to monitor trends and changes in the health and socio-economic status of Maori in order to assess the impact of policy and programmes (Te Hoe Nuku Roa Research Team 1999, p.9).

Te Hoe Nuku Roa is based on a number of assumptions which acknowledge that Maori are not homogeneous, and that change is occurring amongst Maori in terms of *paihere tangata* (relationships), *te ao Maori* (cultural identity), and *nga ahuatanga noho-a-tangata* (socio-economic circumstances) (Te Hoe Nuku Research Team 1999, p.13). These assumptions have been developed into a framework, based on four axes, to assess the changing socio-economic status of Maori. These axes are: human relationships, Maori cultural identity, socio-economic circumstances, and change over time. A set of six indicators has been employed to describe the four axes. The indicators are: levels of choice, access, participation, satisfaction, information, and knowledge and aspirations (Te Hoe Nuku Roa Research Team 1999, p.13). The researchers hope to provide longitudinal socio-economic information on Maori, and to

assess the level of contemporary Maori well being through the employment of this framework.

Summary

The purpose of this chapter has been to examine the influence of socio-economic status on Maori health development. The National Advisory Committee on Health and Disability, which examined the influence of social, cultural, and economic factors on health development, recommended that it is as important to identify the main factors which protect and promote good health, as it is to develop good policy (National Advisory Committee 1998, p.8). The Committee also recommended that appropriate health intervention strategies be developed at policy and regional levels, and within the health sector (Ministry of Health 1999c, p.58). Consequently, Government not only needs to develop appropriate health policy, it also needs to ensure that health intervention strategies effectively target socio-economic and lifestyle factors which may lead to poor health outcomes.

This is important in terms of Maori health outcomes as an interdependent relationship exists between Maori health development and socio-economic status. International studies have demonstrated that the relationship between health development and socio-economic status is accumulative, has intergenerational effects, and that people in lower socio-economic classes experience higher rates of illness for all forms of disease, virtually without exception (Howden-Chapman 1999, pp.73-78). The challenge for policy makers is to assess the potential impact of macro-social and economic policies on the health of the population (National Advisory Committee 1998, p.14). According to Crampton and Davis (1998), there is also a research imperative to monitor trends, for example, avoidable mortality, in different socio-economic groups to inform policy. Consequently, deprivation and socio-economic status need to become more visible in decision-making (Crampton and Davis 1998, pp.81-84).

State restructuring during the course of the 1980s and 1990s has impacted heavily on Maori socio-economic status, and this has been reflected in the increasing gap between Maori and non-Maori health status. Socio-economic inequities for Maori show in higher rates of hospitalisation, morbidity, and mortality. The Ministry of

Health (1998a) argues that the health sector cannot be held accountable for the socio-economic status of Maori, but “it can be asked how it responds to health needs created by low income and social disadvantage” (Ministry of Health 1998a, p.7). In light of these objectives, the purpose of chapter five is to examine the development of health policy during the 1990s, and to identify the ways in which Government is working to improve health outcomes for Maori through changes to the sector. This includes analysing the response of Government to health issues raised for Maori by state restructuring during the 1990s.

CHAPTER FIVE

Health Policy: Development and Analysis

Introduction

If the process of closing the gap between Maori and non-Maori is to be accelerated, we need both a strategy to achieve it, and the determination and commitment of all agencies to see it achieved.

- Wira Gardiner, Chief Executive, Te Puni Kokiri
(Te Puni Kokiri 1993d, p.4)

In Chapter two, the role of institutions in determining health policy was examined. The purpose of this chapter is to analyse in more depth the development of health policy during the 1990s, and to identify ways in which Government is working to improve health outcomes for Maori through changes to the sector. This will be done by examining policy direction and content. Objectives, including outcome targets, have been set by Government for the majority of issue-based policy and the Ministry of Health (MOH) argues that these targets are required to be both measurable and specific. According to the Ministry, each target should identify a measurable change in health status, or risk, for a specified population within a defined time period (Ministry of Health 1999c, p.3). While it is not possible within the confines of this chapter to examine the results of these outcome targets, this will be addressed in chapter six. Chapter six is a case study of the development of Maori women's health during the 1990s, focusing on policy development and outcome implications for Maori women's health.

Moreover, this chapter will seek to highlight areas where improvement to policy could be made so that positive Maori development occurs. Positive Maori development is seen as essential in improving Maori health outcomes. Te Kete Hauora, the Maori Health Group of the Ministry of Health, recommends that positive Maori development be maintained across all sectors, and that fundamental changes need to be made to the way policy is developed, and implemented, so that this occurs (Ministry of Health 1995b, p.18). This chapter will also assess whether this is occurring in terms of mainstream provider accountability. Increased mainstream responsiveness and

improved access to services for Maori are emphasised by much of the policy issued during the 1990s, and are seen as important tools for realising Maori health gain. The Crown has an objective of decreasing disparities between Maori and non-Maori health status, and whether resultant policy implications are explicit or implicit, the Crown has sought to advance this objective. Rectifying any social, economic, or cultural imbalances which may exist for Maori is a key part of this process (Ministry of Women's Affairs 1993, p.18). Policy development in the later years of the decade has sought to reflect this emphasis.

In a conference report by the Ministry of Health (1998a), Action for Health and Independence: Bridging the gap between actions and outcomes, the Ministry (MOH) acknowledged that, despite improvements over time to Maori health status in a number of areas, the gap between Maori and non-Maori has:

“still widened across the whole spectrum of ill health. [This includes] Sudden Infant Death Syndrome, immunisation rates, glue ear, asthma, youth and teenage pregnancy, youth suicide, self-injury and motor vehicle injuries, cancer, diabetes, stroke, pneumonia and influenza, and mental ill health” (Ministry of Health 1998a, p.5).

As a result of these increases in disparity, the Ministry argued that challenges to improve Maori health lie in: mainstream providers taking responsibility for Maori health; the identification of lifestyle and socio-economic factors that cause ill health; and the development of appropriate frameworks for positive Maori development. Pomare et al. (1995), cited in the Ministry of Health (1998a, p.7), maintain that a key to improving Maori health is “reducing the lifestyle risks contributing to major health problems for Maori”. This requires changing established lifestyle patterns.

The Ministry of Health's (1998a) report was based on submissions from a conference, and from pre-conference Hui, to determine why gaps between Maori and non-Maori in terms of health development and socio-economic status were not closing. The Ministry of Health's aim was to improve mainstream responsiveness to Maori through integrated initiatives based on consultation at the local level. Responses from Hui participants argued that the state of Maori health and actions being taken to improve it, needed to be a more “significant determinant of the performance of the sector, and/or institutions and organisations within it” (Ministry of Health 1998a, p.13). Hui

participants also identified that the level of health sector responsiveness to Maori needed to be improved as the health sector was not making the level of difference to Maori health that Maori consider desirable (Ministry of Health 1998a, p.13).

Participants also identified that Maori service provision should be given greater recognition, funding and emphasis. Maori providers were seen to be struggling for recognition in terms of funding against established mainstream providers (Ministry of Health 1998a, p.13).

In response to these concerns, the Ministry of Health (MOH) recognised that the policy focus on closing the gaps between Maori and non-Maori in terms of health outcomes has not made the difference that it should have. As a result, new goals and strategies have been established by the MOH to identify and target major health risks for Maori. These strategies include improving mainstream responsiveness to Maori, and investing in the development of Maori health providers and the Maori health workforce (Ministry of Health 1998a, p.5). In particular, the MOH recognises that a number of diseases which threaten Maori health may require specific targets. These include:

- cancers - particularly prostate, breast, lung, and cervical cancers
- heart disease
- asthma
- diabetes
- sexually transmitted diseases
- communicable diseases, particularly meningococcal, rheumatic fever, and hepatitis B

(Ministry of Health 1998a, p.6)

Other areas that the Ministry of Health recognises as requiring improvement are: the creation of smokefree environments, immunisation, Sudden Infant Death Syndrome (SIDS), hearing impairment, unintentional injuries, healthy Maori communities, mental health, and reproductive health. Smoking has been identified as the single greatest contributor to premature mortality amongst Maori, both for smokers and non-smokers, in terms of the effects of passive smoking on health outcomes. The Ministry argues that the promotion of smokefree environments for children, in particular, will

contribute to reducing SIDS, childhood asthma, and hearing loss (Ministry of Health 1889a, p.5). A reduction in smoking rates by adults will also contribute to reducing Maori rates of heart disease, lung and other cancers, and improving outcomes for Maori who have diabetes and hepatitis B, among other diseases. Reducing smoking levels for pregnant women and young mothers is identified as being particularly important (Ministry of Health 1998a, pp.5-6).

As the Maori Health Group of the MOH, Te Kete Hauora (TKH) sought to ensure that pre-conference Hui would focus on, and identify:

“practical and measurable action which could be used to develop specific recommendations for action by health and disability organisations, the Health Funding Authority (HFA), and the Government, to improve the health of New Zealanders, and to reduce inequalities in health” (Ministry of Health 1998a, p.12).

Te Kete Hauora argued that the Conference - Action for Health and Independence - was designed to lead a process of change and to shift the focus of health services from “what they do, to what differences they make” (Ministry of Health 1998a, p.12). Te Kete Hauora identified four particular areas that need to be addressed if health outcomes for Maori are to be improved:

- results that are appropriate and which reflect the needs of both Maori and Government
 - indicators that can be used to measure results in the context of Maori cultural values and needs, and demonstrate real improvements in health
 - targets that can be achieved at individual, provider, local, and national levels for Maori
 - service approaches that work for Maori
- (Ministry of Health 1998a, p.12)

Pomare et al. (1995), cited in Ministry of Health (1998a, p.7) argue that in order to encourage these changes as well as responding to existing illnesses, Maori need to have access to quality health services and appropriate health information. Pomare et al. recognised that for Maori, many illnesses, disabilities, and early deaths can be prevented by earlier identification of the problem. This could be achieved through

effective health promotion programmes, and early access to primary services (Ministry of Health 1998a, p.7). The challenge to Government, therefore, is to develop appropriate and effective policy and programmes that will result in improved health outcomes for Maori. This needs to be done by encouraging earlier presentation, providing health education, and improved mainstream accountability.

In order to achieve this, the Ministry of Health recommends that mainstream providers must work in partnership with Maori to reduce barriers and improve Maori access to health services (Ministry of Health 1998a, p.7). The Ministry also comments on the success rate of Maori providers in responding to Maori health needs, but recognises in doing so that Maori providers are:

“too few and too small to turn around poor Maori health status by themselves. Mainstream health services would benefit from developing better relationships with Maori providers, and this would contribute to Maori health gain by assisting them in identifying and filling the gaps in health services to Maori” (Ministry of Health 1998a, p.7).

Government needs to ensure that it sets an appropriate policy direction for the health sector with monitored outcomes to ensure that the general health needs of the population, and those of Maori in particular, are being met. This strategic direction should reflect desired health status outcomes, Government objectives, and community values (Ministry of Health 1993, p.8). Policy should have a long-term focus, and needs to be quantifiable. Quantifiable, monitored outcomes, and effective policy analysis, are two ways policy agencies can be held accountable. This will help to determine whether policy is successfully targeting the needs of populations it is designed to meet.

A necessity for building constructive relationships between policy agencies, and of acknowledging the primacy of the Treaty of Waitangi in improved outcomes for Maori, should also be emphasised. According to Te Puni Kokiri, short-term Government assistance arguably creates distortion, and contributes to inequities in health status (Te Puni Kokiri 1991, p.12). Wilkinson (1998, p.2) supports these arguments and suggests that the best way to attain optimal levels of health for Maori is by pursuing an integrated, evidence-based approach. This approach would make it

possible to identify possible risks and costs to health care decision-making at all levels of the policy process. Benefits to affected populations would also be able to be estimated.

Goals and strategies for Maori health

Puao-te-ata-tu: Daybreak, a report by a Ministerial Advisory Committee to the Department of Social Welfare (1986), had ramifications for all policy agencies. The report emphasised the need for all departments to recognise the culture and needs of their Maori clients. The Advisory Committee identified the need for a responsive operating culture that considered the distinct needs of Maori in the development, implementation and evaluation of policy (Durie and Parata 1993, p.10). The Committee also recommended that it was necessary to identify departmental features which inhibit the effective development of appropriate policy, and which contribute to difficulties in providing for Maori health gain (Durie and Parata 1993, p.21). Following the publication of this report, the Ministry of Health (1993) recommended that systemic and structural responsiveness to Maori also needed to be improved amongst policy agencies.

The Ministry suggested that the development of appropriate policy frameworks which incorporate the principles of Te Urupare Rangapu (1988), Ka Awatea (1991), and Whaia te Ora mo te Iwi (1992), is a first step towards improving systemic and structural responsiveness to Maori amongst policy agencies. The Ministry of Health argues that these documents provide a framework for developing Maori policy, and for the provision of social services (Ministry of Health 1993, p.12). In Te Urupare Rangapu (1988), Government argues that all of its agencies must accept “full and proper responsibility for Maori outcomes in communities, and for Maori values and issues” (Ministerial Advisory Committee on Maori Health 1990, p.6). Government recognised that ministerial agencies are collectively responsible for responding to the needs, concerns, and aspirations of Maori people, and urged that this response be definitive and positive (Ministerial Advisory Committee on Maori Health 1990, p.6). Durie and Parata (1993, p.17) argue that Te Urupare Rangapu provided a framework for Maori policy by “prescribing a relationship between Maori and the Crown which

takes into account Maori structures, Government's commitment to the Treaty of Waitangi, and the devolution of certain roles to iwi authorities".

Through the implementation of Te Urupare Rangapu, Government sought to eliminate disadvantageous gaps which exist between the educational, personal, social, economic, and cultural well-being of Maori people, and that of the general population. Government also sought to promote effective decision-making at the policy level, in areas of importance to Maori communities. Promoting effective decision-making would provide opportunities for Maori to actively participate in policy formulation and service delivery (Ministry of Women's Affairs 1993, p.5). These objectives are seen as being particularly relevant for agencies targeting improved outcomes for Maori. Government intended to create a platform of increased responsibility for improved Maori outcomes through the implementation of these objectives. Through the application of this framework, Government also sought to devolve authority to tribal, or community, groups. Improved responsiveness by both Government and local communities was stressed. Government sought to improve service provision through increased accountability.

Ka Awatea, published by Te Puni Kokiri in 1991, built upon this platform of responsibility for Maori outcomes established in Te Urupare Rangapu. Ka Awatea was the Government's Maori Affairs policy statement, and established mainstreaming as the dominant policy approach. It adopted a disparities approach for purposes of analysis (Ministry of Health 1999e, p.16). The main focus of this document was on the housing, employment, education, and health needs of Maori. Ka Awatea looked at the implications for Maori in terms of socio-economic status from many years of: low educational achievement, poor health, high levels of unemployment, low income, high representation in crime and imprisonment, and high state dependency (Te Puni Kokiri 1991, p.9). Te Puni Kokiri argued that the implementation of single policy initiatives would not lead to a reversal of the disparities between Maori and non-Maori. Rather, the solution lay in improving the New Zealand economy, and in developing policy initiatives to ensure that Maori were able to participate equitably in the social and economic life of New Zealand (Te Puni Kokiri 1991, p.9).

Te Puni Kokiri argued that a reduction in health and socio-economic disparities for Maori could be achieved by appropriate resource allocation, and through collaborative strategies designed to improve outcomes for Maori. Te Puni Kokiri also recommended that quality and up-to-date statistics be provided to support health policy and programmes for Maori (Te Puni Kokiri 1991, pp.37, 65). Te Puni Kokiri emphasised that mainstream responsiveness to Maori needed to be improved, and that Maori needed to be involved in improving their own outcomes. Community development was recognised as a form of effective primary intervention (Te Puni Kokiri 1991, pp.55, 72). Following these recommendations, Te Puni Kokiri argued:

“ . . . we stress not only continued responsiveness but also increased responsibility by mainstream government departments for improving the services they provide to Maori. We also believe that the ability of a Maori policy function to influence and report on policies of other mainstream government departments, where they affect Maori, is an essential part of any future Maori policy statement. Finally, the concept of involving Maori much more closely in the process of identifying their own needs, designing corrective strategies, and executing those strategies should again be included in a future policy statement”
(Te Puni Kokiri 1991, p.72).

In 1992, the Department of Health (DOH) published Whaia te Ora mo te Iwi: Strive for the good health of the people. In Whaia te Ora mo te Iwi, the DOH argued that if health outcomes for Maori were to be improved, then: Maori need to be more involved with decisions at all levels of the health sector; resource allocation priorities need to take account of Maori health needs and perspectives; and culturally appropriate practices need to be developed. Culturally appropriate practices are recognised as integral requirements in the purchase and provision of health services (Department of Health 1992, p.17). In Whaia te Ora mo te Iwi, the Department referred to Clause 7 of the Health and Disability Services Bill. A specific reference in this clause addressed Maori health outcomes, and outlined accountability requirements for health sector agencies on behalf of Maori.

This clause identified Government's acceptance of its responsibility for helping to reduce disparities between Maori and non-Maori (Department of Health 1992, p.23).

This was to be achieved through accountability mechanisms which were defined in Clause 10. Clause 10 addressed purchaser and provider Statements of Intent (SOI) which were to be negotiated annually with Government. Regional Health Authorities (RHAs) and the Public Health Commission (PHC) were required to consult with Maori in the development of their purchasing plans, and strategies to achieve this were to be outlined in their respective Statements of Intent (Department of Health 1992, p.24). Statements of Intent were also required to describe the activities each agency planned to undertake over a three-year period. Targets were to be established against which agency results could be measured (Department of Health 1992, p.24).

In Whaia te Ora mo te Iwi: Maori Health Policy objectives of Regional Health Authorities and the Public Health Commission (1993), the DOH further defined purchasers' responsibilities to Maori. These responsibilities were defined in relation to socio-economic and cultural factors which affected health outcomes for Maori, and created a need for effective data collection to inform purchasing decisions. In their purchasing plans, RHAs and the PHC were also asked to take into account: the range of diseases Maori experience, and the length of time it takes to raise awareness about particular health issues, increase knowledge, and change attitudes and behaviours (Department of Health 1993, p.14). The DOH also asked purchasers to:

- be aware of the demographic structure of their Maori populations. This information was seen as essential in identifying service purchase requirements
 - consider the socio-economic and cultural factors which deter Maori from using health services
 - collect comprehensive health information to ensure effective monitoring of the Government's objectives at funder, purchaser, and provider levels
- (Department of Health 1993, p.17)

In 1995, He Matariki: a strategic plan for Maori health was published by the Public Health Commission (PHC). He Matariki was developed in response to the issues raised in Whaia te Ora mo te Iwi (1992). He Matariki sets targets for Maori public health and develops strategies for working towards those targets (Te Puni Kokiri 1997, p.28). The PHC intended that He Matariki would work to promote public

health and well being. The Commission proposed six public health goals, the sixth of which echoed the Crown's objective for Maori health: that Maori should, in the future, be able to enjoy at least the same level of health as non-Maori. The PHC intended that He Matariki would involve both Treaty partners working individually and collectively to improve Maori public health outcomes. Recommendations focused on empowering whanau to assume responsibility for their own needs. The Commission proposed that this be achieved, initially through whanau-provided stability and cohesiveness, and subsequently through support for the larger whakapapa networks and social structures of hapu and iwi (Public Health Commission 1995, pp.6-8).

The Commission interpreted "public health" as defined in the Health and Disability Services Act (1993). Public health was defined as relating to, or concerning, the: "health of all of the people of Aotearoa New Zealand, or a community or section of such people. Public health is about taking specific measures to improve the health of the community" (Public Health Commission 1995, p.6). Alternatively, public health has been defined by Acheson (1988), cited in Ministry of Health (1998c, p.1), as the "science and art of preventing disease, prolonging life, and promoting health through organised efforts of society". The Ministry of Health argues that public health policies and programmes are long-term investments in better health for all New Zealanders. Public health policies are seen as having the potential to reduce the need for health care, including hospital services (Ministry of Health 1998c, p.1). The Ministry argues that public health strategies can be used to modify the effects of social and physical determinants of health, or to promote behaviour change, such as encouraging healthier lifestyles (Ministry of Health 1998c, p.xi). As a result, the Ministry of Health suggests that there is a need to monitor the state of public health for two reasons: to help us decide where we should be going; and to help us determine if we are getting there (Ministry of Health 1998c, p.1).

Policy provision for Maori

According to Blank (1994), the evaluation phase of the policy process involves a comparison of expected and realised performance levels, compliant with established criteria, as well as an assignment of responsibility for discrepancies in performance.

It is, therefore, a retrospective activity “designed to analyse and strengthen the policy as well as reaffirm accountability” (Blank 1994, p.8). Blank suggests that in addition to clarifying the policy context, it is also necessary to define policy objectives in relation to social values of the population, and subgroups within it (Blank 1994, p.136). One of Te Puni Kokiri’s responsibilities in relation to Maori health development is to monitor Government agencies’ delivery of services to Maori, and to evaluate their performance in terms of outcomes and development. This includes the evaluation of policy, and comparison of actual versus expected outcomes of service programmes.

The provision of service to Maori by other mainstream agencies is regulated by a series of protocols designed and implemented by Te Puni Kokiri as part of its mandate to monitor service provision for Maori. Each protocol examines strategic areas which are considered integral to the provision of adequate, effective, and appropriate services for Maori (Te Puni Kokiri 1996, p.94). Te Puni Kokiri pursues these protocols in its relationships with other agencies. Improvement to health services and outcomes requires the active participation of Government, policy agencies, individuals, and communities, as well as health and disability support services. Additionally, each protocol requires agencies to consult with Te Puni Kokiri about their:

- strategic approach to addressing disparities, purchase agreements, work programme, Key Result Areas, and outcomes for Maori clients
- outlines a process for ensuring that outputs from the two agencies are complementary
- provides for Te Puni Kokiri to develop a process with the agency to monitor its performance in addressing disparities

(Te Puni Kokiri 1996, p.94)

As part of this mandate, Te Puni Kokiri (TPK) reviewed the Ministry of Health’s service provision to Maori in 1997. This review was a follow up to the Maori Health Review of the Department of Health by Durie and Parata in 1993. The Maori Health Review will be examined later in the chapter. A specific purpose of Te Puni Kokiri’s 1997 review was to examine what progress had been made since the publication of the

Maori Health Review (1993), and what still needed to be achieved in order to target the disparities which persist between Maori and non-Maori (Te Puni Kokiri 1997, p.2). Te Puni Kokiri's review team found that the Ministry of Health (MOH) focused on Maori health through outputs specified in the MOH's documents of accountability with the Minister of Health. These documents are the Purchase Agreement, and the Annual Report, respectively.

Both documents report on outputs that relate to Maori health: Output 1.6: Policy Advice on Maori Health; and Output 3.3: Maori Public Health (Te Puni Kokiri 1997, p.31). Outputs are services provided by government agencies to clients. The review team identified that funding for these outputs equals the total funding provided for Te Kete Hauora and He Kakano Oranga. As a result of these findings, the review team argued that responsibility for Maori health outcomes still largely sits with these two sectors of the Ministry (Te Puni Kokiri 1997, p.31). This is in spite of the development of a Responsiveness Plan by the Ministry of Health which requires all sections of the Ministry to take responsibility for Maori health gain. This responsiveness plan requires all sectors within the Ministry to identify objectives and tasks which contribute to Maori health gain, and places a formal expectation on these sectors to contribute to Maori health gain (Te Puni Kokiri 1997, p.6).

The review team also recognised other work undertaken by the Ministry towards improving health outcomes for Maori. This included establishing a monitoring relationship and performance indicators with the Transitional Health Authority (THA), and efforts to improve the Ministry of Health's data collection. Priorities for Maori health gain identified by the review team include: accelerating Maori participation in health development; accelerating mainstream enhancement; proactive collaboration between mainstream providers and Maori; and intersectoral collaboration (Te Puni Kokiri 1999c, p.74).

Te Puni Kokiri's review team identified that the Ministry of Health's provision of services to, and for Maori, included:

- policy advice
- contract negotiation and management

- data specification and collection
- service advice
- programme development
- programme purchasing
- programme implementation
- policy review
- programme evaluation
- secretariat support
- registration, regulation, and inspectorate services

(Te Puni Kokiri 1997, p.15)

Despite these initiatives, the review team identified that the Ministry still needed to develop policy and programmes that are more comprehensive in order to improve health outcomes for Maori. Te Puni Kokiri highlighted the range of work the Ministry has undertaken to improve Maori health, but recommended that more could be done to identify links between resource allocation and areas of Maori need, in the performance expectations of the THA. The review team also found that the Ministry has not fully developed opportunities to focus the monitoring of improvements in Maori health gain. Moreover, the review team found that although the Ministry has been working to improve their data collection on Maori health outcomes, they could do more to identify appropriate incentives to improve the quality of the data (Te Puni Kokiri 1997, p.7). The review team tasked the Ministry of Health, specifically Te Kete Hauora (TKH), with maintaining a strategic focus on Maori health. The review team argued that Te Kete Hauora's role is to ensure positive Maori development through the provision of leadership to both the Ministry of Health, and the sector as a whole (Te Puni Kokiri 1997, p.22).

Te Puni Kokiri's review team recommended that this be done by considering Maori health as a strategic focus area, and through co-ordinated efforts at the policy level across the sector. The review team also recommended that Maori health goals be integrated within the core operations of health sector organisations in order to improve health outcomes for Maori (Te Puni Kokiri 1997, p.22). Te Kete Hauora (TKH) advocates that medium and long-term aims of Maori also need to be promoted

within policy environments, and within the core business of agencies (Ministry of Health 1995b, p.18). These objectives are reflected in Te Kete Hauora's mission statement:

“to lead and influence the strategic direction of Maori health by providing informed policy advice to the Government, and ensuring that the Ministry of Health meets its obligations to Maori as embodied in the Treaty of Waitangi, in order to improve Maori health” (Ministry of Health 1995c, p.10).

Te Puni Kokiri's review team also analysed funding provision for Maori health by the Ministry of Health, separate from that devoted to Output Classes 1.6 and 3.3. In the 1997/98 Estimates for Vote: Health, two output classes were purchased by the Transitional Health Authority from the Ministry of Health for service provision for Maori. These output classes were: Output Class 1: Health Strategic Planning and Policy; and Output Class 3: Public Health Policy. In Output Class 1, \$1 936 000 was earmarked for Maori output funding, while \$690 000 was included for Maori services funding in Output Class 3 (Te Puni Kokiri 1997, p.12). The review team questioned why the only funding specifically identified for Maori health in these Output Classes was the \$7 250 000 earmarked for Maori Provider Development, plus an additional \$300 000 for the MOH to administer it (Te Puni Kokiri 1997, p.12). The rationale given by the MOH for express funding being devoted to Maori provider development was that Maori health provision by Maori will result in services that are more accessible and appropriate to Maori. The Ministry believes this will result in improvements to Maori health status (Te Puni Kokiri 1997, pp.12-13).

This review of the Ministry of Health (1997) followed four years after the Maori Health Review of the Department of Health by Durie and Parata (1993). In this review, Durie and Parata argued that responsibility for improving health outcomes for Maori lay primarily with the Department of Health (DOH). The Department of Health was the Government's principal adviser and agent in the health sector. The roles of other agencies, such as Te Puni Kokiri and the Ministry of Women's Affairs, which have specific health sector mandates, were defined by the policy direction established by the Health Department. The policy-making roles of Regional Health Authorities (RHAs), the Public Health Commission (PHC), and Crown Health

Enterprises (CHEs), were also defined by “operationalising decisions made within policy parameters established by Government” (Durie and Parata 1993, p.4). Durie and Parata argued that the DOH was principally responsible for delivering on the Government’s Maori health objectives. This included monitoring and reporting upon the performance of the health sector in this regard (Durie and Parata 1993, p.4).

Durie and Parata found that the Department of Health, at this time, did not have the capacity to achieve this objective. In their executive summary, Durie and Parata argued that:

“There is no consistent articulation within the Department’s corporate culture of the value of Maori principles and practices, and there is no provision within the various resource allocation processes of the Department that ensures Maori health gains are given priority or indeed, are identified at all. Responsibility for Maori health needs appears to have been relegated almost exclusively to the Maori Health Policy Section and seems not to be understood as a department wide accountability. We consider that the Department needs to take urgent, substantial, and comprehensive action to resolve this situation” (Durie and Parata 1993, p.4).

Durie and Parata recommended that the Department of Health needed to examine its corporate culture and operating environments in order to highlight which features of these environments were contributing to, and exacerbating, the difficulties of providing for Maori health gain. Durie and Parata identified that a lack of integrated corporate culture restricted assessment of what should be deemed important, and that should be incorporated into the work of the Department (Durie and Parata 1993, p.21). The review also identified a lack of responsiveness to Maori by other Government departments. Durie and Parata argued that this lack of responsiveness had manifested itself in disparately low levels of achievement by Maori (Durie and Parata 1993, p.5). Durie and Parata noted that this unresponsiveness was apparent in an absence of consistent provision by the DOH for Maori needs, and was particularly noticeable in departmental business indicators (Durie and Parata 1993, p.22). Durie and Parata argued that there was:

“no short, medium, or long term support for the pursuit of Maori health gain in any of the power statements of the Department, budget allocation, resource

allocation, prioritising of projects, performance rewards or sanctions, processes of decision-making, structural lines of accountability, appointments of Maori staff in total, or to specific positions of power” (Durie and Parata 1993, pp.21-22).

Durie and Parata made the following recommendations for prioritising Maori health:

- the Department of Health’s objective of meeting Maori health should be linked into processes at all levels
- the Department of Health needs to define how various sections of the Department will contribute to Maori health objectives, at what cost, with what resources, and within what timeframe
- the Department needs to define Maori health as an area of risk, and show how it intends to confront the challenges of, and achievement of, measurable health gains for Maori. In order to achieve this, the Department needs to appoint a Group Manager of Maori Health
- Maori health gain needs to become part of the Department of Health’s corporate plan
- funding for Maori health must be at a level that allows for effective policy development, and implementation
- other sections of the Department need to work to support the efforts of the Maori Health Group. It is essential that this work is informed by high quality analysis and expertise in Maori health issues, and in Maori views of what is, and is not appropriate, and effective

(Durie and Parata 1993, pp.28-29)

Policy guidelines issued by the Ministry of Health in 1996 for developing positive Maori development in terms of health status centred on six principles. Regional Health Authorities (RHAs) were required to consider these principles in making purchasing decisions. These principles are:

- equity: decreasing disparities in health status amongst population groups, principally Maori and non-Maori, but also including other ethnic groups, by addressing the need for health gain amongst these groups, with an emphasis on improving Maori and child health

- effectiveness: improving existing services so that improved health outcomes result
 - efficiency: realising that resources are limited, and that choices therefore have to be made
 - safety: mechanisms should be developed and set in place by RHAs to identify and manage discernible risks that legislation and/or regulation have not already addressed
 - acceptability: looks at the participation rates, and the autonomy of affected groups. Acceptability includes improving the responsiveness of services, as well as the need for involving, informing, and consulting people and communities
 - risk management: areas of purchasing decisions that require trade-offs not already addressed by the implementation of the other principles
- (Ministry of Health 1996, pp.11-12)

The Ministry of Health sought to achieve health gain for specific population groups, particularly those with low health status, through the implementation of these principles. Under these principles, Regional Health Authorities were required by the Ministry to: identify issues important to health gain priority areas; to determine cost-effective responses to these issues; and to prioritise services, having determined whether services are cost-effective. This included shifting resources to higher priorities (Ministry of Health 1996b, p.13). These objectives were to be achieved through the development of strategies for achieving health gain. Regional Health Authorities were also required to demonstrate that they had integrated and applied the policy directions of Whaia te Ora mo te Iwi (1992) in all purchasing decisions (Ministry of Health 1996, p.11).

Regional Health Authorities (RHAs) were required by the Ministry of Health to promote health gain for Maori by developing strategies that promote positive development, and by incorporating the above principles in their purchasing decisions. RHAs were also required to have a community participation focus, and to identify issues that are sensitive and particular to each locality. This included identifying regional and local issues important to health gain priority areas (Ministry of Health

1996, p.13). The four health gain priority areas were: child health, Maori health, mental health, and physical environmental health. According to the Policy Guidelines published by the Ministry of Health (1996), priority was to be given to services that meet the requirements of these purchasing principles, and which foster an environment of choice, participation, and autonomy.

In terms of developing strategies to promote health gain for Maori, it was argued that Regional Health Authorities must provide for a wide range of services that acknowledge the diversity amongst Maori. The Ministry of Health argues that allowances need to be made for the impact of gender, age, socio-economic status, and area of residence on health development (Ministry of Health 1996, p.16). Allowances also need to be made for Maori who have active iwi and hapu links, and those who do not, as this can affect the way Maori access health services. The Ministry views services for Maori being characterised by: a Maori kaupapa which recognises culture and management practices; Maori clients; Maori community support; iwi approval; consistency with the wider aims and aspirations of Maori development; and contributing to a capacity for Maori health gain (Ministry of Health 1996, p.80). Te Puni Kokiri argues that health needs to be recognised as a social, political, and cultural resource that can either enable or prevent people, in its absence, from leading socially and economically productive lives (Te Puni Kokiri 1993d, p.6).

Improving health outcomes for Maori has remained a priority for Government throughout the 1990s. The Government's commitment to Maori health was outlined in Nga Aratohu Kaupapahere Hauora Maori: Policy guidelines for Maori health 1995-96, cited in Ministry of Health (1995c), which stated that the Treaty of Waitangi was recognised by the Government as important in relation to Maori health (see chapter three for a discussion of the primacy of the Treaty to Maori health outcomes). These policy guidelines also recognised that Maori health was a health gain priority area in which Government "specifically seeks to improve health status and promote independence" (Ministry of Health 1995c, p.5). The guidelines centred on issues of: empowerment, application of the Treaty to Maori health outcomes, community involvement, and strengthening of whanau. Government also requested that the Regional Health Authorities and the Public Health Commission gave consideration to

the establishment of new Maori providers, and the development of medium term strategic plans to improve Maori health (Ministry of Health 1995c, p.5).

Facilitating Maori involvement, particularly at the primary level, is a strategic policy direction pursued by Te Kete Hauora (TKH), Ministry of Health, in order to improve health outcomes for Maori. Enhancing and promoting self-esteem, personal responsibility, and strengthening whanau are strategic focuses which Te Kete Hauora promotes. Te Kete Hauora views these focuses as support for the Government's Maori Policy Guidelines. Te Kete Hauora has a mandate to: "advocate Maori views at all levels within the health sector in matters of policy, purchasing, and service provision" (Ministry of Health 1995c, p.13). Te Kete Hauora is seeking to develop co-operative and collaborative relationships with key stakeholders in the health sector, and to act as a catalyst to bring about institutional, systems, and behavioural change in order to improve Maori health" (Ministry of Health 1995c, p.12). Te Kete Hauora's role includes challenging disparate views which are not consistent with improving Maori health, managing sector change, developing strategic Maori health policy, and monitoring the effectiveness of service delivery to Maori by the Ministry of Health (Ministry of Health 1995c, p.12).

Te Kete Hauora is responsible for developing strategies to promote Maori health gain, and for providing goals for each of these strategies so that progress can be measured annually. In order to help achieve this, Te Kete Hauora published a strategic management plan, Te Ara Tohu: Strategic management plan for Maori health 1994-1999, in 1995. This plan reflected Te Kete Hauora's primary goals of advising Government on improving Maori health, and monitoring and advising on the impact of health policies on Maori, by setting these goals in the context of a medium term strategy (Ministry of Health 1995c, p.5). Te Kete Hauora is also working to: "influence, facilitate, and enhance the mainstreaming of Maori policy advice throughout the Ministry of Health" (Ministry of Health 1995c, p.7). Te Kete Hauora argues that the current framework for the development of Maori health policy needs to be evaluated from a Maori perspective, and that Maori performance models and indicators also need to be developed (Ministry of Health 1995c, p.21).

Te Kete Hauora identified seven strategic goals to achieve in the medium term (five years) in Te Ara Tohu. Through the implementation of these goals, Te Kete Hauora hopes to: critique existing data, inform on the contemporary relevance of the Treaty; and critique contemporary practices of policy, purchasing, and service provision for Maori. Te Kete Hauora also wishes to develop a Maori health framework which includes concepts, values, structures, and processes that work to promote positive development and health gain for Maori (Ministry of Health 1995c, p.19). These seven strategic goals are:

- Goal 1: an agreed understanding between the Crown and tangata whenua of the place of the Treaty of Waitangi that forms the basis for the improvement of Maori health
 - Goal 2: a model of Maori health is adopted as a framework for the development of policy, purchasing decisions, and service delivery to Maori
 - Goal 3: health funding is allocated in a manner that provides opportunities for the effective purchase of health services for Maori
 - Goal 4: to increase the opportunities for providers of culturally appropriate services to enter the market/sector
 - Goal 5: the MOH and purchasers have the capacity to target and measure the effectiveness of service delivery to Maori
 - Goal 6: the MOH produces quality Maori policy advice as integral to its core business
 - Goal 7: to implement effective and efficient operational management systems to support the business activities of TKH
- (Ministry of Health 1995c, pp.16-17)

Mainstream responsiveness to Maori

The 1997 National-New Zealand First Coalition Government sort to achieve Te Kete Hauora's objectives of encouraging accountability amongst policy agencies for Maori health gain through changed policy direction and reformation of the sector. With the move to a single health funding authority in 1997, Government renewed its commitment to Maori health gain. In the transitional year of 1997/98, the Transitional Health Authority (THA) took over the functions of the Regional Health Authorities. The Transitional Health Authority identified Maori health as a health gain priority

area, and looked to review what services mainstream and Maori providers provided in order to reach this goal. The Transitional Health Authority's mandate from Government sort to include the principles of the Government's Policy Guidelines to RHAs in purchasing decisions (previously outlined), and to develop strategic and operational plans to improve Maori health outcomes. The Transitional Health Authority was required by Government to identify in its strategic plans and business agenda the directions it would pursue, and the ways in which it would seek to ensure that services were available and appropriate. Government required the Transitional Health Authority to fund and purchase services which reflected its strategic direction and policy directions (Transitional Health Authority 1997, p.7).

Under Government direction, the Transitional Health Authority could not be held accountable for all factors affecting health outcomes for Maori. It could influence these factors, however, through the provision of appropriate services, by changing access to services, and by removing barriers through its purchasing strategies (Transitional Health Authority 1997, p.13). The THA noted that it was critical during the transition year that: "momentum is maintained, and there are gains in priority areas such as mental health and Maori health" (Transitional Health Authority 1997, p.8). The Transitional Health Authority's Statement of Intent (1997) specified performance criteria to measure responsiveness to Maori, and looked to implement a Treaty perspective in purchasing decisions. The THA argued that:

"with the evidence of poorer health status and following consultation with Maori, it is recognised that there is a need to develop Maori providers to a point where they can offer a range and configuration of services that specifically meet the needs of Maori. The THA is also committed to increasing the responsiveness of mainstream services to the needs of Maori" (Transitional Health Authority 1997, p.30).

The Transitional Health Authority noted that each Regional Health Authority had developed a Maori Health Strategic Plan based on health need and utilisation data. As a result, each RHA had developed strategies to pursue appropriate provider configuration and service mechanisms to achieve positive health outcomes for Maori (Transitional Health Authority 1997, p.30). The THA sought to develop a National Maori Health Strategy by building on these strategic plans, and to establish a

framework for a national funding agency in order to achieve health gain for Maori (Transitional Health Authority 1997, p.30). The THA was replaced by the Health Funding Authority (HFA) as the single funder/purchaser of health care in 1998. The Health Funding Authority was required by Government to establish a strategic framework for improving Maori health, and to identify how it proposed to implement this framework. The result was the Health Funding Authority's Maori Health Policy (1998). The purpose of the HFA's Maori Health Policy was to identify Maori issues in the health sector that required attention. The Health Funding Authority acknowledged Maori health as a health gain priority area (HGPA), and required providers to reflect this priority in their dealings with Maori. Providers were required to demonstrate responsibility to Maori, and to show how they intended to implement this policy. Health Funding Authority Maori Health Gain Priority areas included: smoking, immunisation, diabetes, oral health, hearing, asthma, injury prevention, and mental health (Te Puni Kokiri 1999c, p.75).

The Health Funding Authority argued that:

“Maori health is a specifically identified HGPA. The provider will therefore establish a Maori Health Policy that reflects that fact. In developing this policy, the Provider will take into account the Purchaser's strategic direction for Maori health in terms of minimum requirements for Maori health based on the Treaty of Waitangi. Crown objectives for Maori health and specific requirements negotiated from time to time with the Purchaser. The Provider will specify how it intends to implement this policy. In particular, the provider will identify those services it will deliver as explicit contributions to Maori health gain priorities, how these services will be measured to ascertain what benefit is evident, and other additional opportunities that may exist for furthering Maori health gain” (Health Funding Authority 1998a, p.4).

In the Ministry of Health's Crown Statement of Objectives for 1999/00, the Crown aims to improve the health of all New Zealanders. This is to be facilitated through improved local participation, early intervention, properly integrated services, and health promotion (Ministry of Health 1999a, p.1). The Crown's fundamental health statement is: “Government health and disability policies are aimed at making real gains in the health status of New Zealanders so all enjoy the benefits of good health,

and maximise their potential to live a full life” (Ministry of Health 1999a, p.1). The Crown hopes to improve New Zealanders health status by: increasing public certainty about access, quality, and security of health services; placing greater emphasis on population health approaches; and acknowledging the special relationship between Maori and the Crown (Ministry of Health 1999a, pp.2-4). Population health approaches seek to improve health outcomes for all New Zealanders, particularly those who traditionally have had less healthy outcomes. The Crown acknowledges that, in order to improve health outcomes for Maori, it is necessary to strengthen links between Maori health and other aspects of Maori development. The Crown emphasises that the development of co-ordinated, and integrated services will contribute to better health and disability outcomes (Ministry of Health 1999a, pp.3-4).

Summary

The purpose of this chapter has been to analyse the development of health policy during the 1990s, and to identify ways in which Government is working to improve health outcomes for Maori through changes to the health sector. These changes include increased levels of accountability to Maori and improved mainstream responsiveness. Over a five-year period from 1994 to 1999, Maori Health Policy has highlighted: Maori provider development, Maori workforce development, enhancing the responsiveness of mainstream health services, and intersectoral initiatives (Ministry of Health 1999e, p.8). These initiatives were developed, in part, in response to Maori criticism that mainstream providers were not delivering appropriate services, reflected in poor rates of access by Maori. Government also recognised that a wide range of determinants contributed to poor standards of health for Maori, therefore, a comprehensive range of policy and services needed to be introduced (Ministry of Health 1999e, p.8).

The Ministry of Health and Te Puni Kokiri have also identified that challenges to Maori health lie in: mainstream providers taking responsibility for Maori health; the identification of lifestyle and socio-economic determinants that cause ill health, such as smoking and the impacts of economic restructuring during the 1990s, respectively; and the development of appropriate frameworks for positive Maori development (Ministry of Health 1998a, p.5). As a result, the Ministry of Health has targeted a

number of areas and specific diseases which it identifies as important contributors to lower standards of Maori health. Government needs to ensure that tools to improve Maori health are appropriate and timely, and that emphasis continues to be accorded to attaining health gain for Maori. Government should also support the growth and development of new initiatives in Maori health (Ministry of Health 1999e, p.4), with an objective of addressing the health disparities between Maori and non-Maori.

Participants at hui in 1998 argued that as current levels of sector responsiveness were not making the difference necessary to Maori health, that Maori service provision should be given greater recognition, funding, and emphasis (Ministry of Health 1998a, p.13). Maori provider development schemes have witnessed exponential growth during the 1990s, yet many of these providers are unable to offer comprehensive services due to limited funding and a lack of venture capital. For Maori, these issues contribute to lower standards of health, despite Government's commitment to Maori health as a health gain priority area. Maori health has been a priority area for health since 1984, yet the statistical evidence (see chapters three and four) available suggests that Maori health status is static or regressing.

Maori health has not improved relative to that of non-Maori during the 1990s despite, or maybe because of, reformation of the health sector. Reformation of the health sector in the early 1990s devoted attention to reduced Government fiscal outlay and increased individual responsibility. Policy direction reflected this emphasis by devoting attention to fiscal outlay by providers and encouraging a profit focus over one of health gain (see chapter 1 for a discussion of this relationship). Reformation of the health sector following the election of the National-New Zealand First Coalition Government in 1996 saw a return to a single funder/purchaser format, and a new emphasis on improved health sector responsiveness to Maori.

Despite these initiatives, gaps between Maori and non-Maori in terms of health status remain. The Ministry of Health has identified future directions for improving Maori health outcomes based on current levels of mainstream and Maori health provision, and on current standards of Maori health. Emphasis remains on increased accountability and mainstream responsiveness, and reinforces the need for earlier presentation and diagnosis. The Ministry also recommends that, in order for funding

levels to be appropriate to achieve this, providers need to have access to quality, up-to-date statistics, and need to be aware of the demographic profile of the Maori population in their region. Chapter six examines the implications for Maori women's health development as a result of policy development during the 1990s, mainstream responsiveness, and future policy direction as identified by the Ministry of Health. Chapter six also seeks to determine what can be done in terms of health strategies to promote health gain for Maori women.

CHAPTER SIX

Case Study: the impact of policy change on Maori women's health

Introduction

As discussed in previous chapters, Maori health gain is dependent on positive Maori development, increased mainstream responsiveness, and attention being paid to lifestyle and socio-economic factors which are often primary determinants of health. Designing strategies to improve responsiveness should be a priority concern, in conjunction with a long-term focus. The aim of this thesis has been to relate the changes which have occurred in health policy during the 1990s to Maori health development. More specifically, have disparities of health outcomes between Maori and non-Maori in terms of health status been exacerbated by health reform during the 1990s? The purpose of this chapter is to examine changes to the health status of Maori women during the 1990s as a case study. It will examine the impact of policy on Maori women, and assess the effectiveness of services developed by local, regional and national agencies to address the health needs of this group. This chapter will also seek to highlight the benefits of health promotion for improving rates of primary access and overall health gain for Maori women. Moreover, it will attempt to suggest what can be done to reduce barriers to health services for these women.

At an International Women's Health Congress in 1990, Murchie presented a paper on the state of health of indigenous women, focusing on the state of Maori women's health in New Zealand. Murchie argued that Maori women's health outcomes resulted from a combination of socio-economic and political factors. These factors are:

- paternalistic attitudes by the medical profession and Government to Maori women's health
- high levels of disadvantage suffered by Maori women in terms of socio-economic outcomes

- reactive policy that attempted to relieve symptoms and which did not target the causes of poor health
 - unfavourable statistical comparisons with non-Maori
 - inadequate education and cultural deprivation
 - policy approaches that devoted scant attention to health promotion strategies
- (Murchie 1991, pp.8-9)

Murchie recommended that, in order to target these factors, Government needed to recognise the effects of a neo-colonial environment on Maori health development, and to recognise the contribution of Maori women at all levels of health determination. This included acknowledging the role played by Maori women in preventing ill health, and in promoting wellness (Murchie 1991, p.9). Murchie also recommended that the role of Maori women in promoting good health for the whanau be encouraged, and that greater funding be made available for research and health promotion programmes (Murchie 1991, p.9). Maori women are seen as the family's *poutokomanawa*. They are the structural support for other whanau members, and of the wider community. Consequently, as the development of whanau health is often largely dependent on the health of Maori women, an obvious starting point for policy is to address the health and socio-economic needs of Maori women. Government needs to take into account the wider links between the whanau, community, and national population in policy development. Te Tomo (1999) argues that policy development should also reflect community aspirations for autonomy and effective health strategies.

Sector strategies to improve outcomes for women

Pressure to improve health services for women in New Zealand began in the 1970s as a result of independent women's health clinics being established. These clinics provided women with alternative health options such as the use of Depo Provera and certain IUDs for contraception, improved birthing options, and breast and cervical cancer detection and treatment. Health personnel at these clinics also lobbied for increased representation in decision-making on issues affecting women's health. A need was identified for health service provision to be "integrated, comprehensive, and

appropriate” (Ministry of Women’s Affairs 1992, p.46). As a result of these actions, Government began to monitor health outcomes for women in the 1980s. The Ministry of Women’s Affairs, the Ministerial Advisory Committee on Women’s Health, and the Women’s Health Policy Unit of the Ministry of Health were responsible for reporting to Government on health outcomes for women, and for establishing policy initiatives (Ministry of Women’s Affairs 1992, p.47).

Responsibility for improving women’s health outcomes in New Zealand now primarily lies with the Ministry of Women’s Affairs (MWA). The Ministry of Women’s Affairs was established in 1984 and is required to monitor outcomes for women. This includes monitoring policy implementation to ensure that objectives for Maori women are being pursued. The Ministry is required to assist Government in enabling women to gain “autonomy in all aspects of their lives, and within the social and cultural context of their own families, iwi (tribal), or other groups” (Ministry of Women’s Affairs 1992, p.7). The Ministry is also responsible for reporting to Government on mainstream responsiveness in providing quality outcomes for Maori women. In Advance Women’s Health: Kokiritia te Hauora Wahine: a checklist for Regional Health Authorities and Crown Health Enterprises (1995), the Ministry of Women’s Affairs sought to monitor whether strategies had been designed by Regional Health Authorities (RHAs) to meet the differing health needs of women. The checklist posed a series of questions. Specifically, have the RHAs:

- established and demonstrably implemented health promotion and education policies designed to address women’s needs?
- developed a three-year strategy to improve Maori health which acknowledges the distinctive health needs of Maori women?
- used formal and informal processes to consult with women of different ages and cultural backgrounds, etc, to identify the key health needs, priorities, and preferences for women in the region?
- established mechanisms for monitoring and responding to the effects of social change on women’s health?
- set standards for review of service provision that includes meaningful involvement from women in the community?

(Ministry of Women’s Affairs 1995, pp.17-19)

The Ministry argues that both the formal and the informal sections of the health sector need to consider whether there is an opportunity at each policy or programme juncture to improve health outcomes for Maori women. The Ministry also advocates that at the selection phase of the policy process, strategies are included that reduce or remove negative impacts on women in terms of health development (Ministry of Women's Affairs 1996, p.24). Government needs to consider whether the distinct health needs of Maori women are being catered for in policy, at a formal level, or only through informal level initiatives such as the Maori Women's Welfare League's Healthy Lifestyles Programme, and community-based or marae-based clinics.

The Ministry of Women's Affairs, arguably, plays an important role in effecting positive health outcomes for women. The Ministry's vision is to make a difference for women in Aotearoa New Zealand (Ministry of Women's Affairs 1998, p.3). The Ministry seeks to improve the lives of women where they are disadvantaged in relation to men, and the lives of Maori women where they are disadvantaged in relation to non-Maori women. Gender analysis is the principal policy method of achieving these objectives. As a policy component, gender analysis became part of the core business of the Ministry of Women's Affairs following the Fourth World Conference on Women in 1995. Gender analysis was developed in order to prevent women being disadvantaged in terms of policy development and implementation. According to the Ministry of Women's Affairs (1996), gender analysis seeks to contribute to an improvement in women's social and economic position by reflecting women's life experiences and needs in policy (Ministry of Women's Affairs 1996, p.5).

In response to the objectives of gender analysis, Government developed a set of outcomes that represent a commitment to achieving equitable outcomes for women (Ministry of Women's Affairs 1996, p.16). As the Government's primary provider of gender specific analysis, the Ministry of Women's Affairs works to achieve these outcomes for women. Government outcomes for women are:

- equity
- opportunity and choice

- full and active participation
- adequate resources
- no discrimination
- a society that values the contribution of women

(Ministry of Women's Affairs 1996, p.6)

The purpose of gender analysis is to see that these outcomes are incorporated in policy development by other governmental agencies. Gender analysis is concerned with discovering the causes of inequity, and aims to achieve positive change for women. Gender analysis attempts to address the underlying causes of disadvantage, and seeks to ensure that policy is effective and responsible, and correctly targets affected groups (Ministry of Women's Affairs 1998, p.3). Quality policy advice is one of the main objectives of gender analysis. According to the Ministry of Women's Affairs, gender needs to become an integral component of all "policy development and service delivery". Women are the major users of health services, therefore they services should be appropriate to their needs (Ministry of Women's Affairs 1996, pp.6-7, 10).

The Ministry of Women's Affairs argues that services need to take into account differences in men's and women's lives in terms of health status. These differences include the fact that women are often primary caregivers, and that lower incomes affect women's health status (Ministry of Women's Affairs 1995, p.7). Furthermore, the Ministry recognises that Maori women have distinct needs arising from their health status which is often lower than that of non-Maori women (Ministry of Women's Affairs 1995, p.7). The Ministry of Women's Affairs also plans to develop a Maori Women's Analysis Framework so that gender analysis can be placed within a Treaty of Waitangi context (Ministry of Women's Affairs 1998, p.13).

During the 1990s, there has been increasing acknowledgement by Government of the role played by Maori women in terms of whanau and community health development, and service provision. According to Workman (1996a, p.12) there is a growing recognition of the role of Maori women "particularly in health initiatives as caregivers, providers, service managers, and policy makers". Participants at Hui such

as Te Ara Ahu Whakamua (1994) noted, however, the continuing relative invisibility, or “policy invisibility”, of Maori women and the need to rectify this situation (Te Puni Kokiri 1994b, p.7). Policy invisibility is described as when the concepts used by a particular frame of reference define out or exclude some classes of problem. As a result, these classes of problem cannot be addressed by the policy (New Zealand Royal Commission on Social Policy 1988, p.304).

Health outcomes for Maori women

In 1984, the Maori Women’s Welfare League (MWWL) conducted a study, Rapuora: Health and Maori Women, which examined Maori women’s perceptions of health, their health status, and lifestyle risk factors. This was a study “of Maori, by Maori, for Maori” (Murchie 1984, pp.5, 11). In examining Maori women’s health status and their perceptions of health status, the League examined 153 variables which were split into three groups: health-specific variables, culture-specific variables, and socio-demographic features and lifestyle activities. The League study concluded that the important influences on health outcomes for Maori women included:

- the degree of their cultural affiliation, including attendance at hui
- knowledge of *he mate Maori*
- the role played by whanau and the wider community in determining women’s health status

(Murchie 1984, p.35)

The study also examined major influences on health status and life-experience measures. Health maintenance and improvement measures involved variables controlled, or largely controlled, by the women involved. Weight control, physical activity, smoking, and excess alcohol consumption were believed to be part of the physical environment where “personal choice” was the deciding factor (Murchie 1984, p.56). For example, the women interviewed knew that smoking was bad for their health but continued to smoke, anyway, as it was one factor of their lives they felt they had some control over. Weight control and exercise fell into the same category. For example, the data shows that death rates for Maori women are particularly high for chronic respiratory disease, lung cancer, and other forms of heart disease. Chronic respiratory disease includes asthma, unspecified bronchitis,

emphysema, and chronic airway construction (Te Puni Kokiri 1993c, p.12). The majority of these diseases are caused or exacerbated, by smoking. Maori women have a 69 percent higher death rate, and 204 percent higher hospitalisation rate from lung cancer than non-Maori women (Te Puni Kokiri 1993c, p.39).

A significant finding from the Maori Women's Welfare league's study related to the generally poor health status of the women involved and that of their whanau. Parental care provided by some of the women for their whanau was felt to be inadequate, often through no fault of their own, but related to the poor health status of the women. Through information gathered from GPs and other sources, these women were shown to be actively seeking health care for their children yet the results were often derisory, and significant premature mortality amongst the women was occurring (Murchie 1984, p.12). These results indicate the influence of outside factors on health status. A number of women, mainly young women, also reported difficulties in obtaining appropriate and satisfactory health care.

Under the study's terms of reference, the introduction and employment of health promotion and preventative techniques were seen as an investment for improving the future health of Maori women, in general, and their whanau. The League recognised that investing in preventative health services reduces later demands on the resources of the Department of Health, and on the Departments of Social Welfare and Justice (Murchie 1984, p.92). The study, however, did hold promise for the future from a number of aspects. From a planning perspective, information gathered had demonstrated areas that required attention, and possible avenues by which policy could address these areas. The women identified areas of concern from personal, whanau, and community perspectives, and suggested that investment in health promotion and prevention could help to redress problems in these areas. Additionally, the women involved had demonstrated the ability to undertake demanding research, and had displayed the:

“ability, adaptability, and most importantly, the cultural sensitivity to plan, carry out . . . analyse the responses and put forward ideas for a healthier *Te Iwi Maori*” (Murchie 1984, p.5).

The Royal Commission on Social Policy (1988) recognised the role played by Maori women in health promotion and protection of their whanau, and recommended that these perspectives be incorporated in policy. The Commission's terms of reference included examining the requirements for dignity and self-determination for individuals, families and communities, and opportunity for all people to develop their own potential (Royal Commission on Social Policy 1988, p.236). Self-determination was defined as:

“people being able to express themselves and their needs, to make genuine choices, and to experience safety and security. Autonomy and a reasonable amount of control over their lives and events are also considered deeply important to self-determination” (Royal Commission on Social Policy 1988, p.236).

Submissions to the Commission argued that in order for health outcomes for Maori women to be improved, culturally specific and appropriate solutions needed to be developed. Moreover, Maori women needed to retain an effective amount of control and autonomy so that adequate care was provided (Royal Commission on Social Policy 1988, p.244). Furthermore, submissions acknowledged the role Maori women play in the development and maintenance of programmes such as *Kohanga Reo*. The success of *Kohanga Reo* was given as evidence of the ability and resourcefulness of Maori women to “initiate, develop, control and manage resources in the best interests of their own people” (Royal Commission on Social Policy 1988, p.174). The Commission also acknowledged that the resourcing of Maori women's initiatives based on *kaupapa Maori* would contribute to increased autonomy in health care decisions for Maori women and their whanau (Royal Commission on Social Policy 1988, p.183). In addition, proposals to the Commission highlighted the need to address barriers to effective health care provision that many Maori women face. These proposals argued that necessary improvements to the system should include:

- easier access to health facilities in rural areas
 - health programmes and clinics to be set up on marae
 - encouragement of a closer liaison between community and medical services
 - representation of Maori authorities on Area Health Boards
- (Royal Commission on Social Policy 1988, p.183)

These submissions were accompanied by a resolution from the Commission that an urgent need existed for the economic development and self-determination of Maori women to be addressed in policy (Royal Commission on Social Policy 1988, p.183). Subsequent research during the late 1980s and 1990s into Maori health outcomes reinforced the Commission's findings. In an examination of policy reform and women's health in New Zealand, Chick and Pybus (1988) argued that women are amongst those least well served by current health services and policies. Chick and Pybus suggested the reasons for these inadequacies lie in a blend of historical and contemporary factors which shape perceptions of health and health care services. This blend includes economic and political interests that shape policy and provision (Chick and Pybus 1988, p.125).

Chick and Pybus (1988, p.15) noted that women were becoming more critical of contemporary health care provision as they became better informed. As a result, they are seeking "better health deals" for themselves and their families. Chick and Pybus recommended that in order to combat the negative effects of these factors primary health care receive a higher community and national profile, with particular reference being paid to women's health. These findings resulted from an examination of a report by the Public Health Nursing Review Committee. Chick and Pybus noted that there were a number of omissions from the report. In particular, nowhere in the document was there any mention of women as a group with particular health care needs. Moreover, Chick and Pybus argued that the needs of Maori were discussed in a racially discriminatory tone (Chick and Pybus 1988, pp.136-137).

Practical implications for policy development include determining the level of assertiveness Maori women possess in seeking preventative care. In a study conducted by Prichard in Omahu, Hawkes Bay from January 1991 to December 1992, the most striking practical implication to emerge was that the majority of women studied were not assertive in seeking preventative care. As a result, Prichard recommended that policy and providers develop strategies to increase rates of access to preventative care for Maori women (Prichard 1992, p.i). Overall, Prichard concluded that the study had helped the women involved to be more aware of the health choices they make, and the reasons for these choices. The women involved

based their choices on belief systems. These belief systems provided a valid basis for the health choices made, choices that were often contrary to research findings. For example, this group of women continued to smoke despite knowing that this is in total variance to medical research knowledge (Prichard 1992, p.156). Statistics from the New Zealand Cancer Society and the Department of Health indicated that in 1992 about 57 percent of women aged 15 years and over smoked. They suggested that in some areas this figure was as high as 75 percent for Maori women (New Zealand Cancer Society and Department of Health 1992, p.16).

Prichard also found that the study has: “helped these women to become more aware of why they make the choices they do in relation to health” (Prichard 1992, p.152).

Significant findings from Prichard’s study included:

- Maori initiatives set up by Maori people in a complementary relationship with mainstream public health services may prove more attractive to Maori than mainstream or Maori-provided services by themselves. Maori will not frequent a service simply because it is run by Maori
- since the recommendations of the Maori Women’s Welfare League in the Rapuora study in 1984, the dietary habits of Maori women have changed. They are now eating more fruit and vegetables, and consuming less fat
- more than half the women were receiving social welfare benefits, and experienced hardship as a result
- many of the women experienced feelings of powerlessness and an inability to stop or change events
- due to economic restructuring, most of the women were interested in finding ways to reduce the cost of health care

(Prichard 1992, pp.4-6, 76, 154-156)

Other studies on health outcomes for Maori women’s health include that by the West Auckland Women’s Centre, Feeling Stretched: Women and families in transition (1994), which looked at the impact of income, social costs, and policy-induced change on Maori women’s health. This study examined the impacts of social and economic restructuring since 1990 on the health and well being of West Auckland women who had children or dependants under the age of 25. The women involved in this study

identified a number of primary concerns that affect their health, and which had implications for their socio-economic status and that of their whānau. The study centred on examining the increasing feminisation of poverty, particularly that of Maori female poverty, a lack of power to change their circumstances, and increased barriers to primary health care services.

The women interviewed also indicated that they had struggled to meet increased family costs and responsibilities following the restructuring of the public sector. They felt that doing more for their families meant compromising their own employment options and restricted choice. The option of further education to improve their employment opportunities was restricted due to escalating costs both for the women and for their dependents. The women's main concerns were:

- the negative impact on women's health of their diverse roles and increasing family responsibilities
- women's marginalisation in part-time work
- lack of financial independence
- increased levels of debt and the feminisation of poverty
- lack of representation

(West Auckland Women's Centre 1994, p.5)

Overall, the women felt that "problems of affordability" limited their options and forced them into circumstances virtually beyond their control. Problems of affordability were reflected across all income groups (West Auckland Women's Centre 1994, p.71). These circumstances included limited health options, with the women citing cost as interfering with what they knew to be crucial prevention measures against ill health (West Auckland Women's Centre 1994, p.72). Women in the study struggled to meet the increased costs of raising a family, and consequently had to make sacrifices to meet education, clothing, food, and shelter requirements for their children. Health care was often one such sacrifice. The study also indicated that there was a need for dialogue to take place between policy-makers and communities which would allow communities to make their own decisions. The study concluded that:

“enabling communities to define their own priorities and to plan and implement strategies to achieve better health will lead to the development of healthy policies” (West Auckland Women’s Centre 1994, p.136).

The West Auckland Women’s Centre also determined that some policy decisions could damage women’s health. This occurred through a marginalisation of women’s lives at the policy level. Policy decisions, therefore, needed to start with women as a focus (West Auckland Women’s Centre 1994, p.17). The chance of Maori women becoming economically independent under a market framework were severely diminished by restricted educational and employment options. Pahl (1989), cited in the West Auckland Women’s Centre (1994, p.136), argues that it is impossible to separate families from their socio-economic environment; that inequalities in the wider society are translated into inequalities within families, and vice-versa. Pahl argues that: “social and economic policy plays a crucial role in this process, whether by reinforcing patterns of inequality or by compensating for structural inequalities”. The study found that treating the needs of families as generic merely serves to deepen dependencies and exacerbate intergenerational inequities. Assuming that all families and women have similar requirements ensures that the needs of specific groups remain hidden, thereby exacerbating the poor socio-economic position of many Maori women (West Auckland Women’s Centre 1994, p.131).

Health sector initiatives to improve outcomes for Maori women

As previously discussed in chapter five, Regional Health Authorities (RHAs) were required by Government, during the 1990s, to provide evidence that their relationships with Maori were culturally responsive, showed high rates of Maori participation, and recognised the integrity of each client’s culture. These practices were designed to improve management’s capability to recognise Maori health needs. However, while each RHA was required to show improved levels of mainstream responsiveness and Maori provider development, improvement rates varied significantly (Ministry of Health and the Public Health Commission 1996, p.159). Community group and marae-based initiatives which seek to improve health outcomes for Maori have also been developed. In terms of improving health outcomes for Maori women, a number of these groups emphasise the provision of services to Maori women who may face

access barriers to health services, or who are reluctant to seek health care for themselves.

Table 7 outlines the programmes developed in different areas of the country, and the services they provide to Maori women. These programmes include Te Puna Oranga in Christchurch, which provides sexual abuse counselling and education services for Maori women, and Wai Health which has developed a cervical screening programme. This programme has a catchment area that stretches from Auckland to Dargaville. Other programmes include the Tipu Ora programme based in Rotorua which provides health promotion programmes for Maori women and their children, and the Whare Rapuora Maori Women's Health Clinic, Auckland (Statistics New Zealand 1993, p.155).

Table 7: Maori women's health programmes

Area	Project group	Services provided
Henderson, Auckland	Wai Health	Cervical and breast screening programme
Auckland	Te Ha O Te Oranga Ngati	Health and social service Provision for Maori
Auckland	Auckland Healthcare	Child and Family Services for Maori
Auckland	Nga Ringa Awhina Trust	Supports the Whare Rapuora Maori Women's Clinic. Employs health promotion workers and women working with Plunket to help Maori mothers
Lower Hutt and Central Auckland ;	Maori Health Programme	Community health programmes
Wellington	Nga Tapuhi Whakawhanau	Maori midwifery service for Maori women in the Wellington region
Christchurch	Te Puna Oranga	Sexual abuse counselling Re-educating Maori women to promote wellness and self-esteem

Sources: Statistics New Zealand *All About Women in New Zealand* 1993, p.155

Takoa: *directory of Maori organisations and resource people in New Zealand* 1998, pp.41-46

Re-educating Maori women is a significant part of the approach adopted by both Te Puna Oranga in Christchurch, and the Auckland Healthcare Child and Family Services. Both of these organisations argue that educating Maori women as to who they are as Maori, and teaching them basic life skills, are community participation strategies that can make a difference. The brief of Child and Family Services, Auckland Healthcare, is: “We aim to provide a service that will benefit the Maori community, enrich their knowledge, and enhance their abilities in their quest for a positive response to their severely challenged health status” (Takoa 1998, p.41). Both organisations seek to educate Maori women socially and economically, and in the ways of whanau and whakapapa; in other words, what it means to be a Maori women in the twentieth century. Re-education does not, however, address more immediate issues such as poverty and deprivation, and the resulting sacrifices many of these women have to make between health care and food, shelter, or heating for their families.

In 1988, the Maori Women’s Welfare League (MWWL) developed the Healthy Lifestyle Programme (HLP) based on the Rapuora study of 1984. This programme promotes healthy lifestyles by using netball as a medium to reach young Maori women. The *kaupapa* of the programme is to be: fit, proud, and Maori, and is based on health promotion as a process of development within the context of the whanau (Te Puni Kokiri 1993e, p.4). The League promotes smokefree environments as a key part of the programme. The HLP was developed after a need was identified by the League to address health concerns affecting young women, their men and families, and the wider communities in which they live. The Healthy Lifestyle Programme highlights the need for: “alternative interventions for Maori, away from the mainstream and the traditional health sector, which have a strong Maori input and direction” (Te Puni Kokiri 1993e, pp.5, 10).

The programme was designed by the League to have a national focus and demonstrates a commitment to improving the health outcomes of Maori women, their partners, and whanau. Improved health outcomes at this level also have an impact on the general health of the wider community in which they live. In an evaluation of the programme in 1993, Te Puni Kokiri (TPK) defined health promotion as a holistic approach that seeks to prevent disease and improve the quality of life and health

outcomes for individuals, rather than merely treating illness (Te Puni Kokiri 1993e, p.13). Health promotion programmes usually employ the following objectives: raising awareness to the *kaupapa* or programme; increasing participants' knowledge of the health issue and intervention strategies; changing participants' attitudes to the issue and intervention strategy; and changing participants' behaviours (Te Puni Kokiri 1993e, p.13).

In its evaluation of the Healthy Lifestyle Programme, Te Puni Kokiri recommended that:

- agencies recognise the HLP as a key network for Maori women, and that ongoing support of this network is necessary to ensure communication on health promotion issues which are important to Maori women
- the HLP Action Team recognise the health issues raised in the evaluation of the programme, and plan any necessary health promotion interventions with relevant agencies
- agencies committed to reducing tobacco use and its effects amongst Maori people recognise the benefits of working co-operatively on this programme (Te Puni Kokiri 1993e, p.80)

Te Puni Kokiri argued that the growth of the Healthy Lifestyle Programme and responses from participants indicated that the programme was achieving its goals. Participants commented that it was a positive experience for members. Moreover, they felt that those who participate would be likely to benefit from the encouragement, support, and information gained during association with the programme and with the League (Te Puni Kokiri 1993e, p.73). This feedback fulfils a central tenet of health promotion, which is that participants feel good about themselves and feel culturally secure. According to Te Puni Kokiri, self-esteem is nurtured and developed in this environment, which, in turn, enhances participation (Te Puni Kokiri 1993e, p.17).

Socio-economic implications for policy development

Studies, such as *NZDep96*, and statistics from the 1991 and 1996 Census indicate that Maori women live in some of the most deprived areas of the country, and that many

of these women are reliant on welfare as a main form of income. Many of these women have limited employment options, and receive incomes in the lowest, and second-lowest groups. This is equivalent to incomes of less than \$10 001 and \$20 000 per annum, respectively. A study by Horsfield and Evans (1988) also supports these findings. Results from the 1996 Census show that 25 284 Maori women were receiving the Unemployment Benefit, while 32 982 women were receiving the Domestic Purposes Benefit. These figures represent 3.7 percent and 4.9 percent of the population, respectively. In 1996:

- one in every two Maori women aged 15 years and over received a Government benefit in the twelve months previous to the Census. For non-Maori women, this figure was one in five
- Maori women had a median personal income of \$11 200, compared with \$12 800 for non-Maori women
- 33 percent of Maori women had an income between \$10 001 and \$20 000 at this time, while 44.5 percent of Maori women received less than \$10 001 per annum

(Te Puni Kokiri 1999b, pp.10-11)

Te Puni Kokiri argues that the economic restructuring which took place during the 1980s impacted heavily on the industries and occupations where Maori women were most concentrated (Te Puni Kokiri 1999b, p.2). As a result, there was a decline in job opportunities for Maori women. This decline, combined with increased parental responsibilities (as a result of an increase in one-parent families), has limited Maori women's employment options, and impacted on socio-economic outcomes for their families (Te Puni Kokiri 1999b, p.2). Kiro (1999) argues that structural changes within Government have led to greater insecurity for Maori women, particularly in terms of income and employment, while placing greater emphasis on these women to care for their families in an era of economic uncertainty.

A large percentage of Maori women experienced increased family commitments during the 1990s with little or no accompanying income adjustment. Some of these women are supporting families on as little as \$15 000 a year, or less. In 1996, 43 percent of Maori women were raising children as sole parents, compared with 19

percent of non-Maori women (Te Puni Kokiri 1999b, p.8). For many Maori women, low income is only one barrier to accessing health care for themselves and for whanau. Other barriers to health care for Maori women include, but are not limited to: education, housing, transport, health policy, cost of treatment, communication, and area of residence. Statistics show that while rates of General Practitioner (GP) access by Maori women is at a rate significantly lower than what it should be, access by Maori children approaches the norm. Pomare et al. (1995) argue these statistics indicate that Maori women are seeking health care for their children at the expense of their own health (Pomare et al. 1995, p.162).

Socio-economic and health statistics for Maori women during the 1990s demonstrate that:

- life expectancy of Maori girls at birth steadily increased from 56 years in 1952 to 73 years in 1992 but remains lower than that for non-Maori girls
- Maori women continue to have more children than non-Maori women
- Maori women tend to have children at a younger age than non-Maori women, and as a result have different participation patterns in post-compulsory education and training, and in the labour force
- The number of Maori women enrolled in formal tertiary education has more than doubled in the last eight years
- Maori women are vulnerable to unemployment. In 1996, the unemployment rate for Maori women was 19 percent compared with 7 percent for non-Maori women
- Maori women in the labour force continue to be concentrated in low employment growth sectors
- 41 percent of Maori children aged 0-14 years live in families with an income of less than \$20 000, compared with approximately 20 percent of non-Maori children

(Te Puni Kokiri 1999b, p.3)

Joanne Hayes, a consultant for Ngati Whatua in Auckland, is one of a number of researchers who believe that a substantial gap exists between the policy level and the community, or grass roots, level (Rahu 1999; Foster and Fitzgerald 2000; Keefe-

Ormsby, Robson, and Rochford 2000). Hayes (1999) argues that policy often does not address the realities of day-to-day living for Maori and the implications of this for health care. Hayes suggests that a reassessment of the policy process should take into account: policy evaluation and implementation, community strategies, and the health and socio-economic needs of the community. Practical assessment includes acknowledging the fact that Maori are diverse, and that offering assistance through iwi alone may miss a significant percentage of Maori. Durie (1992) argues that comprehensive health options for Maori need to be developed during the policy process. Durie claims that it is not sufficient to:

“simply package information into acceptable bundles for distribution to iwi. A more active negotiating process to clarify relationships, goals, and the implications of restructuring is necessary” (Durie 1992, p.9).

In a joint report with the Ministry of Women’s Affairs on key issues affecting Maori women’s lives in terms of demographic trends, family formation, education and training, work, and income, Te Puni Kokiri (1999b) argues that one of Government’s strategic objectives is to:

“extend economic and social opportunities by significantly improving the health, employment, education, and housing status of Maori. A key factor in achieving this objective will be the ability of mainstream agencies to accurately assess the needs of Maori women and their families and develop and target interventions which meet these needs. To date, such an approach has been hindered by a lack of information on Maori women” (Te Puni Kokiri 1999b, p.2).

Te Puni Kokiri comments that although Government has clearly stated its objective of improving the health, employment, education, and housing status of Maori, the ability of mainstream agencies to improve outcomes for Maori women will be a “key success factor” in achieving this objective (Te Puni Kokiri 1999b, p.19). Te Puni Kokiri argues that the challenge for mainstream agencies is to recognise the differing needs and expectations of Maori women, and to develop unique, targeted policy and programme responses to meet these needs (Te Puni Kokiri 1999b, p.19).

Policy development: has health gain occurred for Maori women?

In 1996, the Northern Regional Health Authority (NRHA), later North Health, published two policy documents: Hauora Wahine Maori: a discussion document on Maori women's health, and The Health of Women: Strategies to improve the health of women: te kaupapa whaka whai oranga mo nga wahine. In the latter document, which was a gender consultation exercise with Maori and Pacific Island women in the region, the NRHA recognised that benefits to other sections of the population can occur through the introduction of gender-specific strategies to improve health outcomes for women. In a document released in 1998, The Health of Women: a consultation report: te kaupapa hauora mo nga wahine, the Health Funding Authority (HFA) reviewed this gender consultation exercise.

This review by the Health Funding Authority found that the women consulted by North Health emphasised that every woman wants to be responsible for her own health and for that of her family, yet a number of factors were preventing this. The women consulted by North Health, both Maori and non-Maori, argued that the health system lacked a holistic and cultural perspective. Furthermore, the medical profession was described as having a restrictive and intimidating attitude. The women involved in the study desired a health system that embraced a holistic perspective, was less dominated by male non-Maori GPs, and which had adequate female representation (Health Funding Authority 1998c, pp.4, 21).

The women involved in the North Health study indicated a desire for a system where equal, participatory relationships were encouraged, and transparent, accountable policy was produced. The study also identified a need for: primary care access to be more readily available, and quality resourcing, funding and monitoring of outcomes. Improved provider responsiveness was also highlighted. The women also identified that they wished to be responsible for the health of their whanau. As a result of this consultation exercise, a number of services were introduced by North Health that catered expressly for the health needs of Maori women. Overall, this study identified a need for:

- health promotion, information, and primary prevention
- service delivery and primary care

- access and awareness
- intersectoral collaboration
- workforce development
- a national health strategy for women to be adopted
- the Treaty of Waitangi and Ottawa Charter to be incorporated into future women's health planning and documents

(Health Funding Authority 1998c, pp.9, 15)

North Health sought to improve confidence in the system by introducing consultation processes with Maori women, and through introducing gender-specific strategies. During the course of this process, North Health management identified that more health care options need to be available to Maori women, and that Maori women need encouragement to use these services, both for their own health requirements and that of their whanau. North Health management felt that the health of the region as a whole could be improved by the introduction of gender-specific strategies. North Health identified "areas of potential health gain" that management felt were large and distinct enough to justify gender-specific strategies. These broad areas were: diseases and conditions, health-related behaviours, and service delivery and information (Northern Regional Health Authority 1996b, p.6). Within these broad areas, fourteen specific areas were identified where North Health thought health gain could be made. North Health sought to help women improve their health outcomes by providing them with improved health options, information, and appropriate purchasing services (Northern Regional Health Authority 1996b, p.vi).

The 14 specific areas where North Health felt health gain could be made were:

- alcohol consumption
- breast cancer
- cervical cancer
- depression
- dieting
- family planning
- physical and sexual abuse
- sexually transmitted disease

- smoking
- unintentional injuries
- urinary incontinence
- information needs
- service delivery
- disability needs

(Northern Regional Health Authority 1996b, pp.6-19)

Women involved in the consultation process felt that North Health had not integrated previous policy documents and initiatives, such as Advance Women's Health, the Treaty of Waitangi, and the Ottawa Charter into proposed programmes (Health Funding Authority 1998c, p.14). The women felt that North Health's role was limited to the provision of health and disability services when a need existed for an acknowledgement of, and provision for, social, economic, and environmental determinants of health in policy (Health Funding Authority 1998c, p.21). The women expected that accountability would be displayed through co-operative and collaborative initiatives with other sectors, and that the health authority would lead such initiatives (Health Funding Authority 1998c, p.21). Emphasis was also accorded to the need for more transparent and accountable policy which reflected a holistic perspective.

Important themes to emerge from this process were the need for: health promotion strategies, improved service delivery, informed choice, increased awareness of options, and greater access to primary care (Health Funding Authority 1998c, pp.4, 9). Primary prevention was particularly emphasised and the women desired a health system that "empowers women to have influence both as consumers and as participants in health care decision-making at the policy and service levels" (Health Funding Authority 1998c, p.21). Many participants also wanted better information from North Health and Maori providers on what services were available, and how to access them (Health Funding Authority 1998c, p.9).

Other important developments in terms of advancing Maori women's health include two Hui held in February 1995, the recommendations from which formed the basis for

a projected Maori Well Women's Programme. Participants at both Hui emphasised the need for a Maori women's health programme to address the unique health concerns of Maori women. Recommendations from the Hui emphasised the need for an appropriate policy context, national co-ordination, and the public health advancement of Maori women. This includes the need for specific policy development to ensure the public health needs of Maori women are appropriately and specifically addressed (Public Health Commission 1995b, pp.5-10). Hui participants also recommended the introduction of a long-term plan to work towards the re-establishment of a Ministerial Women's Advisory Committee to the Minister of Health which had existed prior to the 1991 Health Reforms (Public Health Commission 1995b, p.10). Delegates at both Hui looked to Government and the health sector to:

- develop healthy public policy
- create supportive environments that recognise and implement Maori health concepts and practices
- strengthen community action through recognition of control by iwi Maori over their own health outcomes. This includes equitable access to health resources and the health dollar

(Public Health Commission 1995b, pp.9-11)

Delegates indicated that Maori women's health could be improved through the provision of appropriate and timely services and information so that Maori women can lead full and productive lives proportionate to their partnership status under the Treaty of Waitangi. The Crown became a signatory to the Ottawa Charter in 1987 and delegates suggested that the Charter needs to be seen and used as a tool to promote total health care for all Maori, but especially for Maori women (Public Health Commission 1995b, p.6). Hui participants sought to "reposition Maori women in the health equation" (Public Health Commission 1995b, p.12). Recommended ways that this could be achieved included the development of joint policy proposals by Te Ohu Whakatupu, the Ministry of Women's Affairs, Te Puni Kokiri, and Te Kete Hauora to improve health outcomes for Maori women by developing a Maori well women's programme.

Moreover, delegates suggested that all programmes be developed in such a way that barriers to appropriate service delivery to Maori women were eliminated. Delegates also highlighted the need for an integration of health and socio-economic objectives so that Maori women are able to achieve equitable health outcomes. Delegates indicated that this would require appropriate resource allocation and funding from an integration of all government agencies. A final recommendation was that an integrated Maori women's health service be developed to encompass life cycle health issues from preconception to post menopause (Public Health Commission 1995b, pp.3-4).

Summary

The purpose of this chapter has been to examine the impact of policy changes on health outcomes for Maori women, and to specify areas that require attention if these outcomes are to be improved. Health promotion and education programmes are a recommended way of achieving this, and are practised by community groups such as Te Puna Oranga in Christchurch, and Tipu Ora in Rotorua. Other health promotion programmes include the Healthy Lifestyles Programme developed by the Maori Women's Welfare League which is based on health promotion as a process of development within a whanau context. This programme recognises that improvements to health outcomes for Maori women will more than likely result in health improvements for the whanau. Health promotion programmes are a community or population approach requiring a range of strategies, not just health education. Te Puni Kokiri argues that health promotion places emphasis on changing our social environment, and that this in turn enables us to change health behaviours "by making healthy choices the easy choices" (Te Puni Kokiri 1993e, p.13). Health promotion has been identified as a viable method of improving health outcomes in the long term. Government strategies to improve mainstream responsiveness should also be a priority concern.

Both Te Puni Kokiri and the Ministry of Women's Affairs recognise that Maori women's life experiences have dramatically changed over the last years of the twentieth century, and that the impacts of economic restructuring have been particularly severe upon this group. These Ministries suggest that a key Government

strategy should be to improve the health of Maori women through the improvement of socio-economic opportunities. This strategy centres on improving the health of Maori women through improving their employment, education and housing options (Te Puni Kokiri 1999b, p.2).

In conclusion, the impact of policy changes during the 1990s on the health outcomes of Maori women cannot be determined without examining changes to socio-economic determinants as well (see chapter four for a discussion of this relationship). Maori women have suffered higher unemployment rates since State restructuring began in the mid-1980s, experienced greater barriers to health care through lower incomes, and have less educational qualifications than other population groups. Many Maori women also experienced increased family commitments during this time. This compounded the effects of limited income. According to the Health Funding Authority, disparities between Maori and non-Maori have been largely related to the greater socio-economic disadvantages faced by Maori as a whole, and to a lower use of primary health services for various reasons (Health Funding Authority 1998b, p.45).

Delegates at the consultation hui held at Hamilton and Ngaruawahia in 1995 emphasised the need for greater access to primary health care, preventative care strategies, and health promotion programmes in order to improve health outcomes for Maori women. Gender-specific strategies, such as those developed by North Health, are also seen as an important means of achieving this goal. Delegates sought the development of a National Maori Well Woman's Programme. They felt that ongoing poor health outcomes for Maori women were a reflection of the inadequacy of policy to effectively target Maori women, and consequently, to improve health gain. Delegates also recognised the importance of reducing barriers to health care for Maori women so that they were able to make effective health care choices, both for themselves and for their whanau. Delegates at these Hui had a vision of advancing the health of Maori women through the provision of information, advice, and effectively targeted programmes which would enable Maori women to lead full and healthy lives (Public Health Commission 1995b, p.4). Te Puni Kokiri recommends that in order to improve health outcomes for Maori women, it is necessary to review

the effects of existing policy and programmes, and to evaluate the degree of access Maori women have to these programmes (Te Puni Kokiri 1999b, p.19).

Conclusion

Overview

The purpose of this thesis has been to examine the influence of policy development on Maori health outcomes during the 1990s, and whether health gain for Maori has been achieved as a result. In particular, it seeks to examine this influence as a result of Maori health development being designated a health gain priority area, and accountability requirements on the part of Government agencies to improve mainstream responsiveness to Maori. This has been done by examining the development of health policy and sector change during the 1990s, and analysing what the implications have been for Maori health development. Having conducted this analysis, this thesis has argued that health outcomes for Maori have stagnated in comparison with those of non-Maori during the 1990s, and that this has been largely as a result of the political and economic climate of the last decade.

The secondary purpose of this thesis has been to determine what the consequences of limited socio-economic options for Maori have been in terms of health outcomes, as socio-economic outcomes have follow-on effects on health development. I have argued that poor socio-economic options can result in trade-offs occurring between housing needs, food, heating, education and health care. The evidence gathered demonstrates that socio-economic outcomes for Maori, although showing some gains from 1991 to 1996, have lagged behind those of non-Maori.

This thesis has argued that these outcomes have resulted from sector reform and state restructuring, and consequent policy development, during the 1990s. Disparities between Maori and non-Maori in terms of both health and socio-economic outcomes appear to have been exacerbated by these changes. The cost for Maori women and their whanau of public sector restructuring has been particularly high. This has been in spite of successive Government efforts to bolster socio-economic and health outcomes for Maori women by increasing services. I have argued that in order to improve health outcomes for Maori, appropriate health and socio-economic policy direction, and improved levels of mainstream responsiveness, need to be developed.

Equitable funding strategies and resource allocation priorities also need to be demonstrable.

According to the National Advisory Committee on Health and Disability (1998, p.8), it is just as important to identify the main factors which protect and promote health gain as it is to develop effective policy. Barriers to health care for subgroups within the population also need to be identified. Consequently, this thesis has focused on identifying what these factors are for Maori, what barriers exist for Maori in accessing effective health care, and what are the options which promote health gain for Maori. These factors have been identified as: health promotion and health education strategies, positive Maori development, improved socio-economic options, and the revision of policy along these lines. Principal barriers for Maori include: lower levels of access to providers; cost of treatment; fewer health care options; the level of access to providers in certain areas is often less than required; and a reduced ability of the system to be responsive (Reid 1999, pp.89-90). Other barriers include: a lack of adequate funding for Maori providers, insufficient resource allocation, health workforce attitudes, inadequate housing, and transport and education issues.

Community-based initiatives, and efforts by providers such as North Health, have also been examined in order to suggest effective policy directions that could be adopted to help ensure health gain for Maori. A number of community programmes are based on: ensuring that programmes are client-focused; managed services which are designed to make a difference to health outcomes for Maori; developing local solutions to local problems; building relationships with resource people and organisations; and drawing on the specialised knowledge of local communities (Ministry of Health 1998a, p.21). Community-based programmes also take into account the wider links between whanau, the community, and national programmes. All of these issues have implications for policy development in terms of effecting health gain for Maori. A number of Maori community health workers (Rahu 1999, Hayes 1999, Puketapu and Pihema 1999) have argued that community-based programmes create opportunities to increase health gain for Maori more effectively than central policy initiatives. Consequently, this thesis has argued that it is important to assess the implications for policy on the development of these programmes.

Hypothesis and analytical approach

Applying this argument to an analysis of policy development during the 1990s, this thesis has attempted to investigate the validity of the following hypothesis:

- **Hypothesis: Disparities between Maori and non-Maori in terms of health status have been exacerbated by health sector reform during the 1990s. The cost for Maori of the economic and political climate of the 1990s has been disproportionate health development compared with non-Maori.**

The hypothesis was developed in an attempt to demonstrate that in spite of targeting Maori health and socio-economic outcomes in policy, particularly through the policy of mainstreaming, that Government has failed to produce equitable health outcomes for Maori. This thesis has asked four research questions in order to support the hypothesis, and to assess if the health needs of Maori are being effectively provided for through policy development. These research questions were:

- **What were the major economic influences on health policy development during the 1990s?**
- **How have these influences shaped health outcomes for Maori?**
- **What adjustments have been made to policy to help improve socio-economic and health outcomes for Maori?**
- **Have any health gains for Maori occurred?**

In order to answer these questions, a combined analytical approach was adopted which employed social policy and sector analysis in order to assess whether health outcomes for Maori have improved during the 1990s. Institutional influence on the policy process was also examined as part of my theoretical framework. The hypothesis and supporting research questions have been examined through: the application of policy documents to the New Zealand health sector; responses from sector interviewees to what is perceived to be occurring in terms of health development for Maori; and examining whether mainstreaming is succeeding in promoting positive health outcomes for Maori. In particular, are government agencies actively promoting improved responsiveness to Maori amongst themselves?

Policy development

This thesis has argued that disparities between Maori and non-Maori in terms of health status have been exacerbated during this time by the process of sector reform. The process of restructuring the health sector by the new National Government in 1991 reflected a continuation of the state and economic restructuring programme which had begun under the Fourth Labour Government in 1984. As part of this restructuring programme, Treasury had moved in the mid-1980s to reduce spending on Vote: Health. Treasury analysts felt that the commitment to health under the Social Security Act of 1938 was unsustainable at current rates due to the fiscal outlay required and the percentage of Gross Domestic Product being spent on health.

Under the Social Security Act of 1938, Government made an open-ended commitment to provide health care for all New Zealanders not determinant on the ability to pay. In contrast with this social philosophy, the economic climate of the mid- to late-1980s and early-1990s was dominated by a neo-liberal agenda of curbed fiscal outlay by Government, reduced State dependency, and increased individual responsibility for social outcomes. This agenda was concerned with improving the efficiency of the market, and a key part of this agenda was a desire to restructure the welfare state. Consequently, the health sector came under review in the late-1980s, the culmination of which was, arguably, the introduction of the 1991 Health Reforms, based on Your Health and the Public Health (1991). Government purported that these reforms would lead to improved health equity and access for all New Zealanders by generating greater efficiency in the system.

The ability of actors to achieve their goals in this new environment depended on the nature of the Government's reform objectives, the resources they had at their disposal, and the amount of social and political power they wielded (Orr 1997, p.62). This was the policy environment Maori found themselves competing in from 1984 onwards, but particularly from 1991 to 1996 as the effects of the 1991 Health Reforms were felt in the health sector, and by the population. Neo-liberal theory considers the presence of socio-economic variables to be naturally occurring parts of the market. As such, these factors will be addressed through the economic structure in place. Neo-liberal frameworks are based on the notions that with regards to health care, individuals are

guided by actions which maximise their options and that they are aware of all options in making their choices.

Under the market ethos, successive Governments promoted the idea that the introduction of choice in health care provision would iron out other variances in health care access and affordability. A major critique of neo-liberal theory, however, is that certain groups are disadvantaged under the system because of a lack of skills, knowledge, or resources and, as a result, they are unable to engage freely in market transactions. As a result, groups with distinctive or special health care needs are seen as being penalised in terms of health outcomes. An implication of this argument is that groups who were already marginalised or disadvantaged in terms of health outcomes, such as Maori, arguably become more so under the market paradigm.

Policy development followed this directional shift until 1996 when the National-New Zealand First Coalition looked to further reform the health sector. The Coalition Government introduced further change to the sector through the Coalition Agreement on Health (1997). This Agreement worked with the existing structure set up by the Reforms of 1991 by maintaining the purchaser-provider split, but reverted to a single funder format. Government was focused on promoting health gain for the population, and on implementing a vision of sustainable development for the health and disability sector over the long term. The Steering Group to Oversee Health and Disability Changes was established to provide advice to Ministers on the impact of the Coalition Agreement on the health sector.

The Steering Group identified a number of issues particularly pertinent to health outcomes for Maori. In particular, it recommended that: Government recognise its Treaty of Waitangi obligations to Maori in terms of health development, and that a new Maori policy framework be developed to ensure that Maori health needs were addressed in the new health sector. In terms of health sector reform during the 1990s, specific policy implications have arisen from the debate over the provisions of the Treaty and the guarantee of *rangatiratanga* to all Maori. The Treaty provides an umbrella for Maori aims and aspirations and is regarded as the framework for expressing health priorities on both a rights and needs basis (Ministry of Health 1995b, p.8). *Rangatiratanga* is defined as a key concept in the Crown's management

of Maori affairs. It is explained as the principle of collective action which underpins the ways in which Maori organise themselves and relate to other parts of the community. *Rangatiratanga* cannot be exercised effectively by people who are disadvantaged in health, employment, education, and income (Te Puni Kokiri 1999c, p.7).

In terms of improved health outcomes for Maori, two key themes emerged from the implementation of the 1997 Coalition Agreement on Health. First, the Steering Group identified that there was a call for the health sector to have an outcome or health gain focus, and in order for this to occur it was important to: monitor and measure performance against set objectives, change behaviour to improve performance, and develop measures to reflect outcomes and desired gains. Second, the Steering Group recognised Treaty of Waitangi obligations on the health sector, and called for the sector to recognise these obligations to Maori under the Treaty (Te Puni Kokiri 1997, pp.19-20).

Government agencies, through documents such as ‘The Government’s Medium Term Strategy for Health and Disability Support Services 1999’ (1999e), sought to target the causes of poor health and to identify ways in which resource allocation and mainstream responsiveness to Maori could be improved. This particular document sought to analysis the medium- and long-term effects of policy, and contains five goals particularly important to achieving equitable health outcomes for Maori. These goals are:

- acknowledging the special relationship between Maori and the Crown
 - decreasing long-standing disparities in health
 - greater emphasis on population health approaches to improve health outcomes for all New Zealanders, especially those who traditionally have less healthy outcomes
 - intersectoral collaboration between agencies and providers to achieve social policy objectives
 - improved capability and adaptability of the health and disability sector
- (Ministry of Health 1999e, pp.4-6)

Once these changes to policy and the health sector have been taken into consideration, a grim picture of Maori health development in the 1990s occurs. The gap between Maori and non-Maori is widening not only in terms of life expectancy, but also in terms of socio-economic status, relative income levels, mortality rates, and the onset of chronic illness or disease (Ministry of Health 1997c, p.62). Statistics New Zealand (1996) and Reid (1999) both argue that in terms of more traditional health status indicators, namely life expectancy, Maori health status has either remained static or even regressed during the 1990s. This followed a period of rapid and extensive economic and state restructuring. In 1996, Te Puni Kokiri advised Government that one of the biggest challenges facing Maori, as a result of public sector restructuring, is the increasingly large number of Maori who are becoming alienated from mainstream social and economic systems (Te Puni Kokiri 1996, p.5).

Government has acknowledged that Maori are disadvantaged in terms of health outcomes by designating Maori health as a health gain priority area. This disadvantage is particularly noted in relation to health outcomes for non-Maori. Analysis of Maori health status during the 1990s highlights the following trends:

- Maori life expectancy has improved during this time but is still five to six years behind non-Maori
- the major causes of death are the same as for non-Maori but the rates are 1.5 times higher for Maori
- Maori are more likely to suffer from respiratory disease, diabetes, cataracts, kidney disease, and circulatory disease than non-Maori, by more than two times in some cases
- incidence of lung, stomach, and cervical cancer remains higher for Maori than non-Maori
- Maori rates of diabetes have always been higher than non-Maori and are increasing
- hospitalisation rates for Maori due to stroke has widened by comparison with non-Maori
- hospitalisation rates for influenza and pneumonia are more pronounced for Maori than for non-Maori, and the gap has widened considerably between 1989 and 1999

- psychiatric hospital admissions for Maori have increased more than non-Maori

(Te Puni Kokiri 1999c, pp. 11-12, 75)

Policy recommendations

Durie (1999) argues that changes to the health sector, by themselves, will not address the disproportionate health balance between Maori and non-Maori. Traditional barriers of access, cost of treatment, fewer health care options, inadequate housing, and transport and education issues, plus a reduced ability of the system to be responsive to Maori were exacerbated in the economic climate of the early- to mid-1990s. Outcomes from the 1991 Health Reforms included a policy and an economic environment that restricted options for Maori through the introduction of more barriers to effective and timely health care. Outcomes for Maori are still somewhat restricted by these factors in spite of a change in policy direction in the mid- to late-1990s. Despite this reversal in policy direction, many Maori still experience adverse economic realities and consequent health sacrifices.

Agencies responsible for the socio-economic status and health outcomes of Maori include the Ministry of Health, Ministry of Women's Affairs, and Te Puni Kokiri. These Ministries acknowledge the barriers that Maori face in improving socio-economic and health outcomes, and are working to target these barriers. In particular, Te Puni Kokiri and the Ministry of Women's Affairs have goals of increased responsiveness in order to improve health and socio-economic outcomes for Maori. Both Ministries acknowledge the disproportionate state of achievement by Maori and their families, in particular that of Maori women. This thesis has identified that a first step towards correcting this situation is the development of effective and appropriate policy.

Policy needs to allow for: access to existing programmes and interventions for Maori; participation in health and education programmes to improve outcomes for Maori; and efforts to enhance health and socio-economic outcomes for Maori (Te Puni Kokiri 1999b, p.19). A cumulative effect of policy should be to produce an environment that enables Maori to improve their health and socio-economic options thereby closing the

gaps between Maori and non-Maori. In this thesis I have attempted to assess policy development, sector reform, and health and socio-economic outcomes for Maori during the 1990s. During this time, Government recognised that health options for Maori are often limited due to adverse socio-economic options. In spite of some improvement to socio-economic outcomes for Maori during the 1990s, particularly from 1991 to 1996, the gap between Maori and non-Maori continues to be substantial. Beaglehole and Chapman (1992), cited in Nuthall (1992, p.i), argue that people at the lower end of the socio-economic scale often do not have the resources necessary to make positive changes to their living arrangements, a situation which they contend is “graphically illustrated” by current Maori statistics, both in health and socio-economic indices.

Policy has, arguably, taken a significant turn in direction by a return to a single funder format, and the promotion of a collaborative, non-competitive environment. Government agencies have also been encouraged to assume greater responsibility for Maori outcomes, and to develop appropriate policy goals. Building healthy Maori communities is an important goal for Government, and in Actions for Health and Independence (Ministry of Health 1998a), the Ministry identifies challenges for all providers if healthy Maori communities are to result. To set effective outcome targets, Te Kete Hauora, Ministry of Health, argues that the health sector needs to work at several levels and promote several strategies. Te Kete Hauora has identified that an effective system needs to work at the following levels: individual/whanau, provider/service, local/community, and national (Ministry of Health 1998a, p.9).

Government should also seek to introduce policy frameworks that acknowledge a need for positive Maori development, and health promotion and education strategies. Health promotion strategies should ideally encompass public health approaches. Government agencies also need to acknowledge the interrelated nature of policy, and the barriers that exist to health care for many Maori and their whanau. Addressing these barriers is a crucial first step in the policy development process. These objectives were included in a 1999 policy document from the Ministry of Health, Crown’s Statement of Objectives for 1999/00. In terms of positive health development for Maori, the Crown aims to:

“maximise the benefits of early intervention, proper integration of services,

health promotion, and involvement of communities in developing their own solutions to their health issues” (Ministry of Health 1999b, p.1).

If health outcomes for Maori are to be improved, the policy process needs to be one that identifies the issues, sets appropriate target outcomes, and works as a collective whole to achieve designated objectives. Gaps between the policy level and the community level also need to be addressed. Proper and full consultation with Maori is one strategy to achieve this. Other strategies include reviewing local initiatives and incorporating successful aspects of these into policy. It is not sufficient, however, to introduce community strategies if Government funding levels and resource allocation priorities are not appropriate. If health outcomes for Maori are to be improved, an environment of collaboration and improved responsiveness is necessary, with actors at each level being responsible for various aspects of improved health outcomes for Maori.

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